Supreme Court, U. S.
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VOLUME III—Pages 867a-1115a
APPENDIX

In the Supreme Court of the United States

October Term, 1978
No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPEAL DOCKETED MAY 31, 1978
JURISDICTION NOTED JUNE 19, 1978

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DOCKET ENTRIES

C.A. No. 72-2272

CIVIL DOCKET CONTINUATION SHEET
DH (Three Judge Court)
RJB, Gibbons

PLAINTIFF: BARTLEY ET AL.
DEFENDANT: KREMENS ET AL.

Date	Nr.	Proceedings
1975		
	123	—Dec. 18, Plffs' response to Court's Order of 12-12-75 and certificate of service, filed.
1976		
	124	—Feb. 4, Certified copy received from the Supreme Court of the U.S. re filing of petition for a writ of certiorari on 1-27-76 as No. 75-1064, etc., filed.
	125	—Mar. 29, Certified copy received from the Supreme Court of the U.S. re notation of probable jurisdiction, etc., filed.
	126	—Jun. 24, Letter from Clerk of the Supreme Court to Clerk of this Court dated 6-23-76 re: transmittal of record, etc., filed.

127—July 1, Answers of the State Schools and Hospitals, State Mental Hospitals and Private Licensed facilities to the May 31, 1973 questionnaire of plffs., etc., filed.

—July 2, Original record transmitted to U.S. Supreme Court, Not including papers No. 20, 110, 113-115.

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128—June 16, Certified copy of Judgment received from the Supreme Court that the Judgment of this Court is VACATED: This cause is remanded to this Court for further proceedings in conformity with this Opinion of the Supreme Court, etc., filed.

129—June 21, Plffs' motion to allow Law Clerks, acting on behalf of and under supervision of attorney and the Guardian Ad Litem of the plff. class to examine medical records of class representatives, certificate of service and memorandum of law in support, filed.

(129)—June 21, ORDER that the defts., et al. shall permit David Ferleger, et al. access to the medical records of members of the plff. class in Penna. state mental institutions, etc., filed. DH 6-22-77 entered and copies mailed.

—July 5, Original record returned from the Supreme Court and forwarded to the U.S.C.A. (Record includes papers No. 1 thru 105—not papers No. 20, 100 and 102).

130—July 8, Plffs' motion to clarify this Court's Order of 6-21-77 and certificate of service, filed.

—July 12, First supplemental record transmitted to U.S.C.A. (Record only includes papers No. 106 thru 129, not including paper No. 113.)

131—July 14, Defts' response to plffs' motion to clarify this Court's Order of 6-21-77 and certificate of service, filed.

(130)—July 25, ORDER that the Order of this Court dated 6-21-77 regarding access is amended, etc., filed. DH 7-26-77 entered and copies mailed.

132—Nov. 2, Plffs' motion to amend and supplement complaint, filed. (Amended and supplemental complaint attached).

133—Nov. 2, Plffs' interrogatories to the defts, filed.

134—Nov. 2, Plffs' certificate of service re: motion to amend, etc., filed.

135—Nov. 9, ORDER dated 11-8-77 that plffs' motion to amend and supplement the complaint is granted: further ordered that the deft shall answer the amended and supplemental complaint within 20 days, filed. DH 11-10-77 entered and copies mailed.

136—Nov. 9, Amended and Supplement Complaint filed.

137—Nov. 11, Entry of appearance of Norman J. Watkins as counsel for defts., Sec'ty of Public Welfare, et al., filed.

138—Nov. 11, Plffs' motion for class action and certificate of service, filed.

139—Nov. 30, Defts' answer and certificate of service, filed.

140—Dec. 5, Brief of Amici Curiae, Pennsylvania Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. and certificate of service, filed.

141—Dec. 15, Defts' answer to plffs' interrogatories and certificate of service, filed.

142—Dec 27, Defts' supplemental answers to plffs' interrogatories and certificate of service, filed.

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143—Jan. 12, Defts' response to plffs' motion for class action and certificate of service, filed.

144—Feb. 13, Plffs' brief on Class Action and certificate of service, filed.

145—Feb. 13, Plffs' brief on Collateral Estoppel Issue and certificate of service, filed.

146—Feb. 15, ORDER dated 2-13-78 that counsel shall advise the Court by 3-1-78 whether they wish to submit additional evidence, etc., hearing and final argument on the merits shall be held before the Three Judge Court on 3-31-78 entered and copies mailed. DH 2-16-78 entered and copies mailed.

147—Feb. 21, Entry of appearance of Robert B. Hoffman as counsel for defts, filed.

148—Feb. 27, Defts' memorandum in opposition to the United States' request to participate as "litigating amicus" and certain evidentiary matters, and certificate of service, filed.

149—Mar. 1, Plffs' memorandum on evidentiary questions relating to admission and medical records, filed.

150—Mar. 10, ORDER that the findings of fact and conclusions of law contained in C.A. 74-1345 are inadmissible on grounds of relevance, etc., that Judge Gibbons and Judge Broderick have agreed with the

contents of this Order, filed. DH 3/13/78 entered & copies mailed.

151—Mar. 15, Plfts' brief with certificate of service, filed.

152—Mar. 20, Defendants' pretrial memorandum, filed.

153—Mar. 20, Copy of defts' pretrial memorandum containing the typographical corrections, filed.

154—Mar. 20, Defts' motion to file defts' pretrial memorandum one day out of time, and certificate of service, filed.

155—Mar. 28, Memorandum, Huyett J., re plffs' motion for certification of a deft., class, etc., filed. DH 3/29/78 entered & copies mailed.

156—Mar. 28, Order, Huyett J., plffs' motion for certification of a deft., class is granted, etc., filed. 3/29/78 entered & copies mailed. DH

(154)—Mar. 29, Order, Huyett J., that defts are permitted to file their pre-trial memorandum one day out of time, filed. DH 3/30/78 entered & copies mailed.

157—Mar. 31, Final hearing, Huyett, J., re: argument to supplement briefs, court gave counsel till 4/13/78 for any additional supplemental briefs, and took issue under advisement, filed.

158—Mar. 31, Plfts' supplemental brief and certificate of service, filed.

159—Mar. 31, Plfts' offer of proof and request for evidentiary ruling, and certificate of service, filed.

160—Apr. 12, Brief of Amicus curiae, United States and certificate of service, filed.

161—Apr. 13, Deposition of Linda L. Glenn, filed.

162—Apr. 13, Brief of The Devereux Foundation, Amicus Curiae with certificate of service, filed.

163—Apr. 13, Brief of The Melmark Home Inc., The Woods School and The Allegheny Valley School for Exceptional Children as Amici Curiae.

164—Apr. 14, Certificate of Service of Jane B. Porcelan, filed.

165—Apr. 14, Plfts' memorandum on need for judicial hearing, filed.

166—Apr. 14, Plfts' memorandum in opposition to admission of "Part A" of medical records exhibits, filed.

167—Apr. 17, Defendants' supplemental memorandum with certificate of service, filed.

168—May 25, OPINION, Gibbons Circuit J., Huyett, J. & ORDER that judgment is entered in favor of plfts. and against defts. Section 402(a)(2), 402(c), 403(a)(2) of Penna. Mental Health & Mental Retardation Act of 1966 are unconstitutional on their face under due process clause of 14th Amendment, etc., filed. Hon. Raymond J. Broderick dissents & will file a dissenting opinion. (49 pgs. $12.25). 5/25/78 entered & copies mailed.

169—May 30, Notice of appeal of defendants to the Supreme Court of the United States, rec'd. 5/30/78 at 10:05 a.m., filed. 5/31/78 entered & copies to: David Ferleger, Esq., Thomas B. Harvey, Jr., Barry A. Roth, Asst. Atty. General, U.S. Atty. in Phila., Louis M. Thrasher, Asst. Atty. General; Herbert B. Newberg & Associates; Robert B. Hoffman, Esq., Asst. Atty. General.

170—June 2, Letter from David Ferleger, Esq. dated 5/30/78 to Norman Watkins, Esq., re: Order filed 5/25/78, filed.

171—June 14, Dissenting Opinion, Broderick, J., filed. ($3.50, 14 pgs.)

172—June 19, Defts' motion for stay memorandum, affidavit of Gerald F. Radke, and certificate of service, filed.

173—Jun. 26, Plfts' notice of deposition of Gerald F. Radke, filed.

174—Jun. 26, Plfts' opposition to request for a stay and plfts' suggestion of need for hearing, with certificate of service, filed.

175—Jun. 26, Certified copy of Order, Supreme Court of U.S. that probable jurisdiction is noted, filed.

176—Jun. 27, ORDER, that a hearing shall be held on defts' motion for a stay of the Court's Order of 5/25/78, on 7/5/78 at 10 AM, Courtroom 434, Reading Station, American Bank Bldg., 6th & Washington Sts., Reading Pa., etc., filed. DH 6/27/78 entered & copies mailed.

177—July 3, Appearance of Kohn, Savett, Marion & Graf, P.C., by Bayard M. Graf, Esquire, for Harold S. Barbour, Ed. D., Director of The Woods Schools, a mental health & retardation facility in Pa. subject to regulation by the deft., Secretary of Public Welfare, filed.

178—July 3, Appearance of Kohn, Savett, Marion & Graf, P.C., by Bayard M. Graf, Esq., for Paul A. Krentel, Director of The Melmark Home Inc., a mental retardation facility in subject to regulation by the deft., Secretary of Public Welfare, filed.

179—July 5, Hearing on motion for stay order of Court pending disposition of appeal to supreme court, witnesses sworn, court took issue under advisement, filed.

180—July 5, Memorandum of Amicus Curiae, United States, in opposition to defts' motion for a stay, filed.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

C.A. No. 72-2272
(formerly captioned *Bartley v. Kremens*)

Institutionalized Juveniles in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, Kevin S.; Richard S.; James Paul M.; Edward B.; Raymond C.; William B.; Francis B.; Maria L.; Thomas W.; Nancy Louise D.; Gina S.; and George S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Secretary of Public Welfare, Commonwealth of Pennsylvania, Frank Beal; John Fong, Director of Haverford State Hospital; Nicholas D'Aluisio, Director of Polk State School and Hospital; C. Duane Youngberg, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Defendants

AMENDED AND SUPPLEMENTAL COMPLAINT

I. PRELIMINARY STATEMENT

1. Children are persons under the Constitution and laws of the United States and are entitled to their protection.

2. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief for violations of their civil rights resulting from the operation of Pennsylvania statutes which permit their indeterminate confinement in institutions for the mentally ill and mentally retarded under color of state law with no right to notice, hearing, counsel and other procedural safeguards. The statutes are challenged on the ground that they conflict with the plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

3. The defendants are those state officials who accept and receive into involuntary custody the plaintiffs, minors, upon the request of parents or guardians such as welfare departments and child care agencies.

4. This case has been before the Court as *Bartley v. Kremens,* 402 F.Supp. 1039 (E.D. Pa. 1975), vacated and remanded, 97 S.Ct. 1709 (1977). This amended and supplemental complaint substitutes new class representatives and informs the Court of recent state statutory developments.

II. JURISDICTION

5. Jurisdiction is conferred upon this Court by 28 U.S.C. 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, exceeds $10,000.

6. Jurisdiction is also conferred upon this Court by 28 U.S.C. 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of state law.

7. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. 2201, 2202, 2281, 2284, Rules 57 and 65 of the Federal Rules of Civil Procedure, all of which relate to declaratory judgments, injunctions and three-judge courts, and by 42 U.S.C. 1983 and 1988, which relate to civil rights actions.

III. THREE-JUDGE COURT

8. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. 2281 and 2284 since the plaintiffs seeks an injunction to restrain defendants, state officials, from the enforcement, execution and operation of portions of state statutes of state-wide applicability on the ground that said statutes are contrary to the United States Constitution. This action was filed prior to the enactment of Public Law 94-381, which amended the three-judge court statutes.

IV. CLASS ACTION ALLEGATIONS

9. The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

10. The members of the class of plaintiffs similarly situated are all persons who are or who may be committed to institutions for the mentally ill and the mentally retarded in Pennsylvania upon application of parents or guardians and without notice, hearing, counsel and other procedural safeguards.

a. Subclass A of plaintiffs includes all those persons under 14 years of age committed under Section 201 of the Mental Health Procedures Act of 1976.

b. Subclass B of plaintiffs consists of all persons 18 years of age or younger committed under Sections 402 and 403 of the Mental Health and Retardation Act of 1966.

11. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

12. Defendant John Fong, C. Duane Youngberg and Nicholas D'Aluisio, directors of the facilities confining the named plaintiffs, are sued as representative of the class of directors of all mental health and mental retardation facilities in Pennsylvania, all of which are subject to regulation by the defendant Secretary of Public Welfare. All the allegations in Paragraph 11 are met with

respect to this defendant class and those allegations are incorporated here by reference.

13. The questions of law and fact involved are:

a. Are the representative parties, and their class members, committed to mental institutions pursuant to the challenged statutes and without notice, counsel, hearing and other procedural safeguards?

b. Do the defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process Clause of the Fourteenth Amendment to the United States Constitution?

V. NAMED PLAINTIFFS

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14. The named plaintiffs sue by their next friend and guardian ad litem, appointed by this Court pursuant to Rule 17 of the Federal Rules of Civil Procedure.

15. Due to the stigma of mental hospitalization and a desire to minimize any possible intrusions on their privacy, the named plaintiffs are designated in this complaint by their actual given names and the initial of their surnames. The full names of the plaintiffs are being disclosed to the defendants and their counsel and will, should the Court desire, be filed with the Court.

16. The first group of plaintiffs, those confined at Haverford State Hospital under the Mental Health Procedures Act of 1976, are *all the juveniles age 14 and*

under committed under Section 201 as of October 31, 1977 to that institution.

17. The second group of plaintiffs are persons with mental retardation confined under the Mental Health and Mental Retardation Act of 1966, Sections 402 and 403 in two institutions, one near Philadelphia in the eastern part of Pennsylvania and one near Pittsburg in the west.

First Group of Plaintiffs; Those at Haverford State Hospital

18. Plaintiff Kevin S., born May 2, 1965, is a citizen of Pennsylvania. He is 12 years old.

19. Plaintiff Richard S. is now 13 years old and a citizen of Pennsylvania. He was born on September 24, 1964.

20. Plaintiff James Paul M. is 7 years old, having been born on November 10, 1969. He is a citizen of Pennsylvania.

21. There is no paragraph 21.

22. Plaintiff Raymond C. was born on September 9, 1964, is a citizen of Pennsylvania, and is 13 years old.

23. Plaintiff William B. was born June 18, 1968, is 9 years old and is a citizen of Pennsylvania.

24. Plaintiff Eddie B. was born October 26, 1965, is a citizen of Pennsylvania and is 12 years old.

25. Plaintiff Francis B. was born January 9, 1967, is 10 years old, and a citizen of Pennsylvania.

26. Maria L., plaintiff in this action, was born August 26, 1965, is 12 years old and a citizen of Pennsylvania.

27. Thomas W., born February 14, 1966, is 11 years old and a citizen of Pennsylvania.

Second Group of Plaintiffs; Those at Pennhurst and Polk State Schools and Hospitals

28. Plaintiff Nancy Louise D., born December 10, 1960, is a 16 year old citizen of Pennsylvania.

29. Plaintiff Gina S. was born on July 30, 1961 and is a citizen of Pennsylvania. She is 16 years of age.

30. Plaintiff George S., was born February 10, 1963, is 14 years old, and is a citizen of Pennsylvania.

VI. DEFENDANTS

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31. Defendant Secretary of Public Welfare is the Pennsylvania State official who, in that capacity, has the power and duty to enforce the challenged statutes and all regulations necessary and appropriate to the proper accomplishment of those provisions and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Mental Health and Mental Retardation Act of 1966, and Section 105 of the Mental Health Procedures Act of 1976 ("Treatment Facilities"), and 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility"). Frank Beal currently occupied that office.

32. Defendant John Fong is the director of Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act

of 1966. It is Fong or his delegate that applications for admission, commitment or release of the plaintiffs must be made. Haverford State Hospital is an approved facility under Section 105 of the Mental Health Procedures Act of 1976.

33. Defendants Nicholas D'Aluisio and C. Duane Youngberg are, respectively, directors of the Polk State School and Hospital and the Pennhurst State School and Hospital, both institutions for persons with retardation. They are charged with supervision and administration of those facilities. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966. It is to D'Aluisio, Youngberg or their delegates that applications for admission, commitment or release of the plaintiffs must be made. See Sections 402(b), 403(b) and 403(c) of the Mental Health and Mental Retardation Act of 1966.

VII. FACTUAL ALLEGATIONS

Haverford State Hospital

34. Haverford State Hospital is an institution for the mentally ill located in a rural area outside Philadelphia, Pennsylvania.

35. The institution's score of buildings cover a large hilly area in one corner of which is Building 14, a building with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles.

26. As of October 31, 1977, there were a total of 12 juveniles in Building 14. Two were committed by

juvenile courts, after hearing; ten were committed under the challenged statutes, having been "volunteered" into the institution by parents or guardians.

27. Entry into the Children's Unit in Building 14 is through a door that is kept locked. When a buzzer is rung, a worker inside comes to unlock the door. The door bears a sign which reads, "Visiting Hours—1:30-4:30 Weekends and Holidays. No evening visits. (signed) Dr. Bernard Kanther."

28. The Unit consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two bare unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory for female patients.

29. In the nursing station is a bank of television monitors which are used to surveil the patients in all areas of the Unit, including the halls and dormitories.

30. Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high.

32. Patients, including the plaintiffs, are punished for misbehavior and for disobedience to staff, and for violations of unit rules in a variety of ways including: restriction to the Unit, "meditation" (an enforced period of standing or sitting in the hallway, with the person forbidden to converse or interact with other patients passing to and fro), or "time out" (lock-up in a bare unfurnished room, including overnight periods, alone).

33. Patients have also been pushed, shoved, slapped and hit by institutional staff with no justification. Pa-

tients have been forcibly medicated with intra-muscular injections as punishment for "acting out" and for the convenience of staff. The plaintiffs have been subjected to these conditions.

34. Aides and attendants are given great power and discretion to impose restrictions on the plaintiffs. Often this is done arbitrarily with no opportunity provided for appeal or review of such decisions.

35. Privileges (such as the opportunity to exercise outside), special events, and even some forms of therapy may be denied to plaintiffs for violations of Unit rules.

36. Unit rules include, inter alia, prohibitions against chewing gum, smoking, name-calling, visiting with parents or others in the dormitories.

37. The admission process includes a pre-admission contact or interview with a social worker and other staff (this may be the same day as admission) and an interview of the child by a psychiatrist, recorded in an admission note on the day of admission. The admission note summarizes the factual and psychiatric basis thought to justify the commitment.

Kevin S.

38. Plaintiff Kevin S. was admitted to Haverford State Hospital on July 18, 1977 pursuant to Section 201. He was born May 2, 1965. He was brought to the facility by his mother and the county child care agency.

39. A July 25, 1977 evaluation conducted by the school at which Kevin S. was in the fifth grade provides as a "diagnostic impression" of him:

> Kevin is a very needy, very angry boy who needs a supportive and consistent environment.

> He is not currently seen as psychotic although there is a tendency toward projection and a lack of controls when anxious. A behavior disorder of childhood is suggested. It should be noted, however, that the emergence of adolesence with its attendant conflicts and changes will in all likelihood, throw additional strains upon the defenses of an already disturbed child.

40. Kevin's mother is separated from her husband, who lives in New York. His brother, born in 1963, is in a foster home.

41. Kevin's mother has a history of serious mental illness and hospitalizations. She has also physically abused Kevin. As a result of these problems, most of Kevin's early life (he was born in a mental hospital) was spent in foster homes. Haverford State Hospital's psycho-social history describes the facts in this regard:

> She Kevin's mother has many schizophrenic-type features, such as tangential thinking, flight of ideas, inappropriate laughter and illogical statements. During the pre-admission interview there were several times when Kevin's response was much more appropriate than was his mother's. When we told the Squires that we could set an admission date, Mrs. Squires covered her face with her hands and made loud and wracking sobs for several seconds, then immediately stopped and, with no sign of emotion, exclaimed that Kevin's admission should be the sooner the better! This sort of behavior was rather inappropriate. However, she does have a caring for Kevin and expresses hope and a positive attitude that she and Kevin will be helped.

Reason for Hospitalization: Kevin was admitted on a voluntary 201a admission, signed by his mother, ———— S. Kevin has a history of much instability within the family. He was born in a state mental hospital, as his mother had requested admission there because she trusted the doctors. He was in a foster home for his first five months while his mother was in the state hospital. He subsequently was in another foster home for a few weeks, when he was seven years old (along with his brother), and again in 1971. He was in another foster home from August 1974, to May 1975, and in another home for a period of two years. Mrs. Squires would place the children because she physically abused them. She was having emotional and marriage difficulties and could not handle Kevin properly.

42. Shortly before his commitment to the institution, school authorities objected to his behavior there; he was allegedly making wierd noises, refusing to do work, and talking back to teachers. He was suspended from school. At home, his mother felt, he was hyperactive, and spent much time playing by himself.

43. During her fifteen years of marriage, Kevin's mother was in a mental hospital many many times; she attempted suicide twice before her children *was* born. As with Kevin, she was in a mental hospital when her elder son was born. When pregnant with Kevin, she returned to the hospital and, she told Haverford State Hospital staff, "lied" to get in again.

44. Kevin's brother, thirteen months his senior, had been in a foster home but at the time of Kevin's admission to Haverford was in a foster home in New York under the

custody of a county social services department. He too had been in a mental hospital.

45. The impression of the institution social worker was, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and confused early life." The social worker noted that Mrs. S actively uses social systems "to the point of abuse."

46. The decision to admit Kevin S. to the institution was made at a meeting at the hospital on July 13, 1977 with hospital staff and a representative of the county child care agency. An admission date of July 18, 1977 was set. No psychiatric report or evaluation was made during that pre-admission interview.

47. After he was admitted, on July 18, 1977, Dr. Mia Marcovici interviewed Kevins S. and filed the following "Admission Note:"

REASON FOR ADMISSION: Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately.

MENTAL STATUS: (Use 2d page if necessary) Kevin is a 12 years, 2 month old boy who was accompanied to the hospital by his mother and Yol Sanders from the Delaware County Child Care Service. He was clean in his appearance and was generally cooperative. He had difficulty sitting still and concentrating on a topic. He was well oriented and spoke in short sentences. It appears that he spends a lot of time in his room building walls or playing with his cars. He has few friends and has difficul-

ties relating to peers. No thought disorder was elicited and denied hallucinations.

The "diagnostic impression" noted after this note was "Withdrawal Reaction of Childhood. 308.1."

48. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 2d Edition* (hereafter, "DSM-II") defines this diagnosis as follows:

> 308.1* Withdrawing reaction of childhood (or adolescence) *
>
> This disorder is characterized by seclusiveness, detachment, sensitivity, shyness, timidity, and general inability to form close interpersonal relationships.

49. There is no indication in the records of Kevin's admission to Haverford State Hospital of his comments or version of the behaviors he was accused of.

Richard S.

50. Richard S. is a Black youth, age 12, who was committed to Haverford State Hospital on June 6, 1966 pursuant to Section 201 by the county child care agency which had and has legal custody of him. He was born on September 24, 1964.

51. There had been a previous attempt to have him admitted to the Adolescent Unit of the same institution but he had not been accepted because of his size and age.

52. Richard S. did not live with his mother until he was two years old (he was under an agency's care) and lived with her at home only until he was four when

he was placed in the child care agency's Children's Cottage. He later lived in another institutional home for children and then at a residential school for difficult students, at which he was placed immediately prior to his commitment to the mental hospital.

53. Prior to his admission, a contact was made with the Haverford State Hospital at which the hospital authorities were told that Richard's problems included "running away from Silver Springs, putting glass in eye, striking resident while asleep, shaving head and breaking car windshield."

54. The staff of the school Richard was in recommended hospitalization to the child care agency which, in January, 1977, six months before his admission, wrote to Haverford seeking his commitment.

55. The first psychiatric evaluation recorded for Richard S. in the hospital records is dated June 6, 1977 by Dr. Miz Marcovicci and states as follows:

> REASON FOR ADMISSION: Inability to adjust to an open setting. History of self harm and running away.
>
> MENTAL STATUS: (Use 2d page if necessary) Ricky is a well developed, 12 year 8 month old boy. He is clean and neat in his appearance. He is well oriented in all three spheres. Ricky looks down to the floor most of the time. His eye contact is limited and he offers no spontaneous conversation. When asked questions he replies in short sentences. He is relevant and coherent. He appears preoccupied. No bizarre or inappropriate behavior was elicited. No restlessness or fidgitness was noticed. He has a

history of low impulse control, self harm, running away and unpredictable behavior.

The diagnostic impression was "Unsocialized Aggressive Reaction of Childhood."

56. This diagnosis is defined in the *DSM-II* as follows:

> 308.4* Unsocialized aggressive reaction of childhood (or adolescence) *
>
> This disorder is characterized by overt or covert hostile disobedience, quarrelsomeness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline.

57. The admission records at Haverford do not indicate Richard S's version of the behaviors of which he was accused. The only "self harm" indicated is the unexplained reference to "putting glass in eye."

58. Within a few days of admission, Richard S. expressed his desire to leave the institution; no attempt was made by institution staff to provide him with an attorney or to advise him of steps to take to obtain his release.

59. By October, 1977, his diagnosis was changed to "Withdrawing reaction of childhood", defined above.

60. The institution's doctor at Haverford prescribed the drug Thorazine to be administered by nurses, without further doctor's order, for any aggressive behavior.

James Paul M.

61. James Paul M. was born November 10, 1969 and was admitted at age 7 to Haverford State Hospital under Section 201 on October 17, 1977.

62. The admission note by Dr. Elizabeth Cheek states as follows:

> REASON FOR ADMISSION: Uncontrollable behavior. Learning disability.
>
> MENTAL STATUS: (Use 2d page if necessary) This eight year old youngster looked cheerful in the beginning but was clinging to the father later on. He was dressed in pair of jeans and a T-shirt. Speech was clear and understandable. There were no abnormalities of gait. Patient was sucking his thumb in the beginning and said, "I am not answering. My Dad will do." He used the phrase "Oh Brother" with a sigh for every sentence. Patient did not sit on a chair for more than 1 minute and changed toys very frequently. Patient was oriented to time, place and person. Pat have vague memories of past but was able to tell about recent things. He cannot remember the immediate things which were asked to repeat. He has short attention span, get frustrated with the toys very easily. Patient was not sure of the side? He did not like the idea of separating from father. Patient gets very anxious if he hears any voice outside. He feels that he should punch everybody if he cannot get things done. He sat very near the father later on.

The diagnostic impression was "Minimal brain dysfunction, learning disability." These diagnoses are not defined or listed in the *DSM-II*.

63. On his first day at the institution, the doctor prescribed the use of Thorazine. During Paul's first week, he was placed in a locked bare room alone, on an "as is necessary basis," on the discretion of non-medical staff.

64. Prior to this admission, Paul had been asked to leave school. At home all day, his behavior deteriorated. His mother died about a year ago. His father works all day.

Edward B.

65. Edward B., born October 26, 1965, was committed to Haverford State Hospital on May 9, 1977 by his father. He was referred to the institution by his psychiatrist who, it happens, is also a full-time psychiatrist in another unit at Haverford State Hospital.

66. Five days before admission, the referring psychiatrist and the parents of Edward B. reported to the social worker that the child had "acted out" at home and in the community. The only specific behavior reported or alleged was that he had thrown a rock through a "window that borders the school" in April, 1977.

67. At this pre-admission meeting, the parents further reported that

> they are policing the boy for fear of his running away, hurting self or others. They are quite concerned that an admission might be necessary when he comes for pre-admission 5/9/77 as they live in neighborhood, and the children call Haverford State Hospital a place for "retards or crazies." Neighbors are now suggesting that Ed is responsible for incidents of destruction in the neighborhood.

68. Edward is an adopted child.

69. The admission note by Ora Smith, M.D. of May 9, 1977 states:

> REASON FOR ADMISSION: Hyperactive with poor behavioral controls; threatens to hurt himself; feels depressed.
>
> MENTAL STATUS: (Use 2d page if necessary)
>
> This 11 year old boy is alert, oriented; and anxious and fearful about hospitalization. Has had a long history of disruptive behavior which is partially controlled by medications.

The "diagnostic impression" recorded in this note is as follows: "minimal brain dysfunction, adjustment reaction of childhood."

70. Minimal brain dysfunction is not defined in the *DSM-II*. Adjustment reaction of childhood is defined as follows:

> 307.1* Adjustment reaction of childhood*
>
> Example: Jealousy associated with birth of patient's younger brother and manifested by nocturnal enuresis, attention-getting behavior, and fear of being abandoned.

The *DSM-II* notes that this and certain other diagnoses are "transient situational disturbances" which "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress."

71. During the many months of his commitment with a diagnosis indicating a short-term problem, the hos-

pital records and evaluations continued, each month, to state an "anticipated discharge date" of "three months." Paragraphs 84-86 below refer to this plaintiff.

Raymond C.

72. Raymond C., born September 9, 1964, was committed by his father to Haverford State Hospital at age 13 pursuant to Section 201.

73. He was referred to a local mental health clinic by his school. The mental health clinic referred him to Haverford State Hospital for residential treatment evaluation.

74. Raymond C., at the time of his admission, was under the jurisdiction of the Juvenile Court, with a background of stealing minibikes.

75. He was admitted to Haverford State Hospital the day he was first seen at that facility.

76. The admission note, dated September 28, 1977, and reflecting the examination performed on the day of Raymond's admission, states:

> REASON FOR ADMISSION: History of uncooperative disruptive and aggressive behavior including run away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem—Admission and evaluation to assist in future planning to meet his needs.
>
> MENTAL STATUS: (Use 2d sheet if necessary) An alert, sad and anxious immature looking 13 year old. Patient avoids (refuses) any conversation with adults other than his parents. He does not evidence any overt physical deficits other than hearing. He does not display anything suggestive or psychosis. His lack of cooperation at this time prevents doing a desirable mental status examination.

The diagnostic impression was one of a "behavior disorder of childhood" and a non-psychotic organic brain syndrome with associated speech, hearing and learning disabilities.

77. Raymond C.'s father had a drinking problem. He died on or about October 30, 1977.

William B.

78. Nine years old, William B. was born on June 18, 1968 and was committed to Haverford State Hospital by his father, pursuant to Section 201, on September 21, 1977.

79. William's parents had separated and divorced when he was an infant. About two years prior to his commitment, he began living with his natural father in a home with his stepmother and two stepbrothers.

80. The admission note by Dr. Mia Marcovicci states:

> REASON FOR ADMISSION: Uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window.
>
> MENTAL STATUS: (Use 2d page if necessary) This 9 years, 3 months old boy was referred to Haverford State Hospital by Media Child Guidance Clinic and Dr. Fittie. He has been in therapy for the past few months and recently his behavior has

deteriorated. He turned on gas burners in the house, smears feces and has taken away and hid his youngest brother's injectible medication for allergies (the desensitize lotion vaccine)

Billy is well developed and neat in his appearance. He exhibited no separation anxiety from his parents and was spontaneous and talkative. He talked about the boy in his head who tells him to do bad "things". He claims to hear his voice but did not see him. He was restless, anxious and destructible. He exhibited some inappropriate behavior in the office. Billy is well oriented and coherent.

The diagnostic impression was "overanxious reaction of childhood".

81. This diagnosis is defined in the *DSM-II* as follows:

308.2* Overanxious reaction of childhood (or adolescence) *

This disorder is characterized by chronic anxiety, excessive and unrealistic fears, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self-conscious, grossly lacking in self-confidence, conforming, inhibited, dutiful, approval-seeking, and apprehensive in new situations and unfamiliar surroundings.

82. William B.'s life with family members subjected him to a situation of extreme inconsistency, disorganization and lack of structure. His natural mother's lifestyle was erratic and she reportedly abused him. His grandparents have given him affection but their handling of him has also been destructive to his development.

83. His mother and his grandparents were not told of the plans for his commitment; they were informed after he was institutionalized.

Edward B., Further Facts (see paragraphs 65-71 above)

84. Eddie B. was admitted to Haverford State Hospital on May 9, 1977, by his parents, very upset, as he had been tricked into going by his parents. He was committed under Section 201.

85. The admission note indicates the facts surrounding his entry into the institution:

From the beginning, Eddie was extremely upset and crying. He was totally unprepared for admission to a hospital. On the way, his parents told him they were taking him to a new school as he could not continue in his present one. Mrs. B. ——— explained that this problem had existed for some time but that he had not been excluded until recently because she was a teacher in that setting and the school had permitted him to remain. To prevent misunderstanding of why he was here, it was pointed out that this was a hospital and that school was a part of the program rather than the primary reason for the children coming. Because Eddie was so upset, I suggested that one of the teachers tell him a little about our school so that he could know this part of the program. Although this was done, Eddie heard very little about what was said because of the way he had been brought for this admission.

Eddie then opened up with many feelings about being tricked into coming by his parents. He ex-

pressed feelings about them not caring for him and wanting to get rid of him. Both parents acknowledge that they had "tricked him" because they were fearful he would hurt or threaten to hurt himself. They admitted that they had not told him until that morning and had omitted the fact that this was a psychiatric hospital. Eddie's response to this was to make promises that he would change if he could stay home. * * * Eddie continued with his fears of being in a "crazy" hospital and of getting hurt by other patients—both adults and children. He also spoke of the high fences and of being kept in, like a prisoner. * * *

During this admission interview, Eddie was told he would not be permitted home for a home visit for three weeks to a month. He responded, "My God, you're trying to kill me." To comfort him, the doctor suggested that he could go on a trip the next day with the other children. His parents interjected that they did not trust that he would not run away. The doctor then agreed that he would not go on the trip.

86. Eddie was not told during this admission process that the institution would help him obtain a lawyer or any legal assistance.

Francis B.

87. Francis B., born January 9, 1967, was 9½ years old when he was admitted to Haverford State Hospital on August 16, 1976 pursuant to Section 403 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4403.

88. This admission was at the request of his father who signed admission forms which were not filled out,

which did not list the son's full name (or, on the Section 403 form, any name at all) or any identifying information whatsoever. On September 7, 1976, the father executed a form under the successor statute, Section 201, asking the hospital to commit Francis B. for care and agreeing that the hospital need not release Francis B., even at the father's request, without at least 72 hours notice.

89. Francis B. comes from a disorganized family which has rejected him. As a social history a month before his commitment indicates, "One of the most distressing aspects of this case is the almost total rejection of Frankie by everyone in his family." His father has a drinking problem, the records indicate that the "parents are in need of help also as there is some question here of physical abuse" and, at the pre-admission interview at Haverford, it was apparent that "Frank could no[t] do right in parent's eyes." There are five children in the family, all boys.

90. The admission note of August 16, 1976 by Dr. Mia Marcovicci which records the psychiatric justification for the commitment notes "difficulties adjusting to school" and that Francis B. "has been described as hyperactive . . . clowning in order to get attention." The diagnostic impression was of "Unsocialized aggressive reaction of childhood," a term the official definition of which is noted above at Paragraph [56].

91. After Francis B. was committed, the institution received background an referral material including a psychiatric evaluation which indicated that "The school seems to tolerate this boy fairly well" and that, despite the "hyperactivity" attribution, "I cannot describe him

as hyperactive. In the first interview his mother seemed more hyperactive than he did."

Maria L.

92. Maria L., born August 26, 1965, was committed to Haverford State Hospital on April 25, 1977 by her mother pursuant to Section 201.

93. The admission note by Dr. Mia Marcovicci states as follows:

> REASON FOR ADMISSION: Difficulties adjusting to school because of aggressive behavior. Difficulties adjusting within the family.
>
> MENTAL STATUS: (Use 2d sheet if necessary) Maria is a 11 year 7 month old girl who came today accompanied by her mother. She speaks freely about her aggressive behavior in school and describes the fights she gets into. She does not respond to limits at home.
>
> She is restless and fidgity. She is well oriented and relates well to the examiner. No bizarre or inappropriate behavior was elicited. She claims that she will miss her brother Danny (suffers from muscular dystrophy) because "we get in trouble together". She does not appear remorseful about her behavior.

The diagnostic impression was "Unsocialized Aggressive Reaction of Childhood. 308.4"

94. Maria L. has resisted the regimentation and directions imposed upon her by the institutional staff; one staff note quotes her as saying, during a meeting with staff and her mother, "I don't have to listen to these staff people, they're not my parents."

Thomas W.

95. Thomas W. was committed to Haverford State Hospital on an emergency commitment which was later changed to a commitment under Section 201. He was institutionalized at that facility on June 2, 1977.

96. Born February 14, 1966, Thomas' parents have an unstable marriage. After a severe beating which resulted in his hospitalization in 1975, Thomas' case came to the attention to social service agencies and his mother and stepfather were arrested.

97. The county child care agency, which has custody of Thomas W., committed him to Haverford from the County Juvenile Detention Center where he allegedly broke a large window, assaulted a staff member and set several small fires.

98. The admission note for Thomas W. states the basis the facility used for his commitment:

> REASON FOR ADMISSION: Fire setting, rages of 5-6 hours, during which he is assaultive, destructive and sets fires.
>
> MENTAL STATUS: (Use 2d page if necessary) Patient is a good looking 11 year old black male who is well dressed. He rapidly became angry as I asked him questions. He admits to fire setting and destructive behavior "because they get on my nerves . . . . they get me mad." He appeared quite bright and was adept at standing up for himself. He has been evicted from school for allegedly exhibiting himself and for sexual behavior toward girls. It is also claimed that he has been involved in sexual behavior with his three year old sister and girls in the

neighborhood. He denied any sexual behavior except with a nine year old neighbor girl. He denied insomnia, anorexia, depression and self-destructive ideation. He said that the only person he trusted in his family was his three year old sister.

Child Care Worker says he's repeatedly run away, goes into rages of 5-6 hours, has demolished dresser drawers and several windows, pulled a knife on a cottage staff member, has repeatedly been assaultive and was reported to be grunting and evoking unintelligible verbage last night at the detention center. He has repeatedly complained that he has asthma, chest pain and liver trouble but physical was negative.

99. Scapegoated in the home, the professionals involved in his case feel, Thomas acts out the marital and family conflict in his daily life.

100. On May 31, 1977, just two days prior to his commitment to Haverford, Thomas W. was given a psychiatric evaluation by Dr. John Fong, a defendant in this action. Dr. Fong evaluated Thomas W. not as superintendent of Haverford State Hospital but, at the request of a county judge, in his capacity as consultant to the court. He found the child to be non-psychotic but dangerous. He also found that Thomas W. disputed many of the behaviors he was accused of and explained that some were a response to mistreatment. Dr. Fong recommended family therapy, having been informed that admission was being arranged to a private facility. Haverford State Hospital information at the time of Thomas W.'s commitment, however, erroneously stated that Dr. Fong recommended admission. Despite the involvement of the

juvenile court and its jurisdiction over Thomas, no court hearing or judicial authorization for the commitment was ever sought or authorized.

Pennhurst State School and Hospital; Polk State School and Hospital

101. Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge. Built in the first decade of this century, it is a overcrowded and understaffed institution, unaccredited by the Joint Commission on Accreditation of Hospitals. Residents generally receive little habilitative programming. Institutional life for Pennhurst residents is regimented and unpersonalized. The facility houses about 1200 people. The institution and its staff are defendants in *Halderman v. Pennhurst State School and Hospital*, Civil Action Number 74-1345 (E.D. Pa., Tried April-June, 1977, pending decision).

102. Polk State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh. It is not served by any public transportation. Now housing about 1700 residents, its rated bed capacity is 1321. Polk was built 80 years ago in 1897; those ancient buildings continue to house the plaintiffs in large dormitory areas, residents sleeping head to head. The institutional conditions are regimented and unpersonalized.

Gina S.

103. Gina S. was committed to Polk State School and Hospital on October 20, 1970 by her mother pursuant to Section 404 of the Mental Health and Mental Retardation Act of 1966, which permitted any two doctors to commit any person upon the certification of said doctors.

104. This statute, Section 404, was declared unconstitutional in 1971 in *Dixon v. Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971) (Three-Judge Court).

105. No legal commitment papers were executed from 1971 until November 25, 1975 (during which time Gina S. remained at Polk) when the plaintiff's mother applied to the defendant director of the institution for plaintiff's commitment under Section 402 of the Mental Health and Mental Retardation Act of 1966.

106. At the age of 6, in 1967, the year her parents were divorced, Gina S. was placed in a county "infants' home." Three years later, in 1970, she was removed by her mother and taken directly to Polk where she has remained since.

107. The certificates of the doctors certifying the need for commitment stated as follows:

a. Certificate No. 1:

(History of illness) Mongolism since birth with moderate retardation.

(Physical and Mental Findings at Time of Examination) Px as noted. Has limited speech. Child can handle most personal care. She has (illegible) heart disease.

b. Certificate No. 2:

(History of illness) Down's Syndrome—moderate retardation. Fair speech and recognition.

(Physical and Mental Findings at Time of Examination) Typical mongoloid features with high palate, small fifth digit; also with gingival hypertrophy, loud systolic m.

108. The report of the psychologist which accompanied the doctor's reports reported the facts of her condition as follows:

(Maturation) Gina is an affectionate and alert little girl of moderate mongoloid appearance. Motor development appears adequate, and she was able to deal with all tasks presented from this standpoint.

(Social Adjustment) Gina was cooperative in the test setting, sitting quietly but responsive to the examiner's questions. Her speech was hard to understand although some single words were very distinct.

(Names of Tests and Results) Stanford-Binet, form L-M: CA: 9-2; MA: 3-4; IQ: 35.

Gina is functioning in the moderately mentally retarded range of intelligence. She can respond well to concrete verbal direction, and is able to use language denotively.

(Diagnosis) Mongolism, AAMD Classification: 64.

Nancy Louise D.

109. Nancy Louise D. was born in 1960, Both her parents were alcoholics. Both her parents were mentally retarded.

110. In 1961, Nancy Louise war adjudicated a neglected child and placed under the guardianship of the county welfare department which placed her in foster care until May 22, 1968 when she was taken directly from foster care to Polk State School and Hospital.

111. On April 12, 1968, the county welfare director executed an application to the defendant director of Polk for the commitment of Nancy Louise to Polk. This was done under the Pennsylvania Mental Health Act of 1951 (*not* the 1966 Act). The child was committed on May 22, 1968.

112. No commitment forms have ever been executed under the Mental Health and Mental Retardation Act of 1966 by the guardian or by anyone else.

113. The defendant director of Polk purports to maintain the confinement of the plaintiff pursuant to Section 402 of the Mental Health and Mental Retardation Act of 1966.

114. The basis for commitment, as described in a physician's certificate attached to the 1968 application is as follows:

> (History of Illness) At age 3½ there was marked retardation—did not walk or talk—began walking at about 4½ years.
>
> (Physical and Mental Findings at Time of Examination) Psych. reports will be submitted—obviously retarded—Physical examination essentially neg. except for poor muscular coordination.

George S.

115. George S., abandoned by his parents, was placed at an early age in the custody of the Philadelphia Welfare Department which, by contract, arranged for Catholic Social Services to provide for his care.

116. Catholic Social Services placed him from the first year of his birth until 6 years later (when he was committed to Pennhurst) with a foster family, Mr. and Ms. C.

117. In 1969, the foster mother was hospitalized and, after her discharge, was temporarily not able to resume care of George. As a temporary measure, George was placed in another foster home; however, because of the crowded conditions in that home, the placement could not be maintained. Catholic Social Services, on behalf of the county welfare department, then applied for and was granted commitment to Pennhurst for a short-term period of 90 days.

118. The days lengthened into years; no placement outside Pennhurst was arranged or obtained despite the fact that George could function in a non-institutional setting.

119. George's foster mother, Ms. S., has maintained continual contact with him, and attempted to regain care of him, only to be rebuffed by the institution and the welfare department, for no proper reason.

120. During his commitment at Pennhurst, George has suffered numerous bites, scratches and other injuries. On one ward where he lived, he was frequently tied to a bench; he would attempt to walk anyway, dragging the bench after him. Until the last year before the lawsuit referred to in Paragraph 121 was filed, George was constantly naked or wearing clothes that were not his; he never wore shoes or stocks on the bare concrete floors of the ward. Pennhurst officials told the foster mother that they medicated George to keep him quiet. On medication, he would sit and rock, his eyes glassy and his attitude sleepy. Off drugs, he is fine and plays and relates to the world.

121. George S. is a plaintiff in *Halderman v. Pennhurst State School and Hospital,* C.A. No. 74-1345, brought to trial in April-June, 1977.

The Statutory Scheme for the Mentally Ill

122. Subclass A, plaintiffs alleged to be mentally ill, are confined to institutions pursuant to Section 201 of the Mental Health Procedures Act of 1977, hereafter, "Section 201." This law became effective September 7, 1976.

123. Section 201, in relevant part, states:

> A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child.

124. There is no time limitation on the length of a commitment under Section 201.

The Statutory Scheme for the Mentally Retarded

125. The members of Subclass B are confined to institutions pursuant to Sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966, hereafter, Sections 402 and 403, under a scheme described and dealt with by the Court in the earlier phase of this litigation.

126. Sections 402 and 403 provides that applications for admission/commitment may be made by:

> A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

Section 402(a)(2); Section 403(a)(2) (identical language in both sections).

127. There is no time limitation on the length of commitments under Sections 402 and 403.

Commitments of Other Persons in Pennsylvania

128. Aside from the members of the plaintiff class, other persons committed to Pennsylvania institutions for the mentally ill and the mentally retarded do so either voluntarily on their own personal volition or for short-term emergency care or after a judicial hearing at which they have the rights to notice, appointed counsel, presentation of testimony in their own behalf, confrontation and cross-examination of adverse witnesses, expert assistance, court-ordered outpatient or partial hospitalization instead of in-hospital commitment. Many juveniles are committed under the statutory provisions guaranteeing such procedural protections, including juveniles in plaintiffs' situations.

Department of Public Welfare Regulations

129. On September 1, 1973, during the pendency of this lawsuit, the defendants adopted regulations regarding the commitment of juveniles, published in volume 37, Pennsylvania Bulletin (Sept. 1, 1973). These regulations continue to apply to Subclass B, the plaintiffs who are persons with retardation. These regulations *do not apply* to Subclass A, those persons committed under Section 201, as allegedly mentally ill.

130. The three plaintiffs technically subject to these regulations are totally unable to benefit thereby, as they are unable to understand the rights stated therein or to exercise them. The applicants for admission (two welfare agencies and a parent) have not and will not utilize those provisions to secure these plaintiffs' rights.

Previous Hospitalization

131. Absolutely none of the named plaintiffs in this action have received mental hospitalization prior to the commitments to the institutions in which they are now confined.

Family Disorganization

132. Families seeking commitment of allegedly handicapped children are characterized by severe stress, dislocation and disharmony. The problems of children are a function of intrafamilial problems and exist in a context of a weakened family structure, with conflict overtly expressed.

133. The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts in the home.

134. Parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes or ignorance or sometimes from malice or ill will. In a significant number of cases, the parental purpose of bringing a child to residential treatment has been to accuse, punish and separate the child from the home. The motivation is not always good.

135. Parents are not particularly good observers of children's behavior and symptoms and, especially in the context of the high feelings that run in situations of conflict, parents are not reliable sources of factual information about the child and his or her behavior.

136. Parents who bring their children to psychiatrists for care cannot be objective reporters of the behavioral background of the child. They often exaggerate and misinterpret the actions of their children and may often react antagonistically to their children.

Effects of Institutionalization

137. Institutionalization is a severe deprivation of one's liberty and may be extremely harmful, resulting in what one of the state's witnesses at trial called "an emotional deficiency disease." Barton, *Institutional Neurosis* (2d Ed. 1966); Goffman, *Asylums* (1961); Belknap, *Human Problems of State Mental Hospitals* (1956); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia* (1970); Vail, *Dehumanization and the Institutional Career* (1966).

138. Institutionalization for mental handicap results in severe social stigma, self-stigmatization, employment and license discrimination and liabilities.

139. In a practical sense, institutionalization may make treatment difficult because of the difficulty in involving the family in treatment and the fact that an institutional setting is less likely to be oriented toward family pathology. As one expert testified on the general ill effects of institutions, "We have to be cognizant of the enormous social toll that institutionalization brings."

Reliance on Psychiatrists Would Be Misplaced

140. The mentally retarded should not be in institutions at all.

141. Psychiatrists can and do err and disagree in making diagnoses and recommendations for institutionalization of plaintiffs.

142. As children who are most likely to be institutionalized are in the lower class, the psychiatrists who evaluate them are at a great distance culturally, class-wise and geographically from the situation in which the children are living, and thus the psychiatrists misperceive behavior.

143. Psychiatric evaluations for commitment are short and not conducted over a sufficient period of time. Children are often referred for hospitalization without exploration of less restrictive alternatives. Over crowded clinics may overrecommend institutionalization.

144. In the stress of the admission interview, a juvenile may not present an accurate picture of his or her mental status and may appear in worse condition than is actually the case.

145. There is pressure on the institutional doctor to agree with any referring psychiatrist's recommendation for institutionalization; the needs of the institution will inevitably affect admission decisions of institutional doctors; the information that largely influences the doctor's decision to commit comes from the parents and any referring psychiatrist.

146. Some psychiatrists may start with a presumption that the person before them is mentally disturbed, thereby leading to a skewed interpretation of the picture presented.

147. Improper evaluations may result from countertransference due to which the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations.

148. There is a tremendous conflict of interest created when psychiatrists are permitted to make institutionalization decisions.

149. Present law permits parents to doctor-shop for doctors who will agree to commit their child.

150. The considerations detailed above apply as well to the mentally retarded.

Factual Basis of Need for Hearing

151. Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults. This is especially true of those persons under 14, who are severely limited in their ability to speak for themselves and of the retarded 18 and under.

152. Assistance of counsel is essential and can help treatment of juveniles and can in no significant way hinder such treatment.

153. Hearings would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation. To the contrary, a hearing would encourage more appropriate resolution of problems and would have a positive and beneficial effect on the child.

154. The opportunity for hearings would not discourage people from seeking treatment for juveniles, but would result in agencies and psychiatrists performing more effectively and in the avoidance of the necessity of hearings in many cases.

VIII. CAUSE OF ACTION

155. By operation of Section 201 and Sections 402 and 403, plaintiffs and their class are detained and incarcerated involuntarily in mental institutions without the right to notice, the right to a hearing or hearings, the right to counsel and, if indigent, appointment of counsel, the right to present evidence and testimony on their own behalf, the right to subpoena witnesses and documents, the right to confront and cross-examine witnesses against them and those who wish them to be committed, the right to independent expert examination and assistance, the right to be involuntarily detained only upon the decision of a disinterested and impartial decision-maker, the right to appeal, other procedural safeguards.

156. By operation of the said statutes, and by defendants' actions in operating, enforcing and executing the same, plaintiffs and their class are deprived of their life, liberty and property without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution.

IX. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Continue jurisdiction of this cause, and the already-convened three-judge court, and set this case promptly for an expedited hearing;

2. Determine by order, pursuant to Rule 23(c) (1) that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged statutes are invalid, void and of no effect on the ground that they violate the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and final injunctions enjoining defendants from enforcing and executing such statutory provisions;

5. Allow plaintiffs and the guardian ad litem their costs herein and reasonable attorney and guardian ad litem fees;

6. Grant such additional and alternative relief as may be deemed by the Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103
215-735-8409, 567-2828
Attorney and Guardian ad Litem
for Plaintiffs

November 2, 1977

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA
[Caption Omitted in Printing]
ANSWER

First Defense

1. PARAGRAPH ONE (1) contains legal conclusions to which NO RESPONSES are required. However, if they are deemed factual in nature they are denied.

2. PARAGRAPH TWO (2) is ADMITTED to the extent that it characterizes the form of the action and the manner in which it is brought; all remaining averments are denied.

3. PARAGRAPH THREE (3) is ADMITTED to the extent that it avers that the defendants are responsible for the custody of the plaintiffs. The characterization of the custody as "involuntary" is a LEGAL CONCLUSION to which NO RESPONSE is required. However, if it is deemed factual in nature, it is denied.

4. PARAGRAPH FOUR (4) is ADMITTED.

5. PARAGRAPH FIVE (5) is ADMITTED to the extent that it purports to characterize the jurisdictional base of this action.

6. PARAGRAPH SIX (6) is ADMITTED to the extent that it purports to characterize the jurisdictional base of the action. The remaining averment, that defendants acted under color of state law, constitutes a LEGAL CONCLUSION to which no response is required. However, if it is deemed factual in nature, it is DENIED.

7. PARAGRAPH SEVEN (7) is ADMITTED to the extent that it purports to set forth the statutes and Federal Rules authorizing plaintiffs' claims for relief.

8. PARAGRAPH EIGHT (8) constitutes a LEGAL CONCLUSION to which NO RESPONSE is required.

9. PARAGRAPH NINE (9) is ADMITTED to the extent that it purports to characterize the form of this action.

10. PARAGRAPH TEN (10) is ADMITTED to the extent that it purports to describe the proposed plaintiff class.

11. PARAGRAPH ELEVEN (11) is DENIED.

12. PARAGRAPH TWELVE (12) is DENIED.

13. PARAGRAPH THIRTEEN (13) is ADMITTED to the extent that it purports to set forth the questions of law and fact involved in this action.

14. PARAGRAPH FOURTEEN (14) is ADMITTED.

15. PARAGRAPH FIFTEEN (15) is ADMITTED to the extent that it avers the manner in which the plaintiffs bring this action, all remaining factual averments are DENIED.

16. PARAGRAPH SIXTEEN (16) is ADMITTED.

17. PARAGRAPH SEVENTEEN (17) is ADMITTED.

18. PARAGRAPHS EIGHTEEN (18) through THIRTY-FIVE (35) are ADMITTED.

26. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-SIX (26) (page 7 of Complaint) is ADMITTED except that it is DENIED that the plaintiffs' parents "volunteered" the plaintiffs into Haverford State Hospital.

27. (Numbered incorrectly in Complaint) PARAGRAPH TWENTEY-SEVEN (27) (page 7 of Complaint) is ADMITTED.

28. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-EIGHT (28) (page 7 of Complaint) is ADMITTED except that it is DENIED that "[a]long the hallway are two bare unfurnished rooms. . . .".

29. (Numbered incorrectly in Complaint) PARAGRAPH TWENTY-NINE (29) (page 7 of Complaint) is ADMITTED.

30. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY (30) (page 8 of Complaint) is ADMITTED.

32. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-TWO (32) (page 8 of Complaint) is DENIED.

33. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-THREE (33) (page 8 of Complaint) is DENIED.

34. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-FOUR (34) (page 8 of Complaint) is DENIED.

35. (Numbered incorrectly in Complaint) PARAGRAPH THIRTY-FIVE (35) (page 8 of Complaint) is DENIED.

36. PARAGRAPH THIRTY-SIX (36) is ADMITTED.

37. PARAGRAPH THIRTY-SEVEN (37) is ADMITTED.

38. PARAGRAPH THIRTY-EIGHT (38) is ADMITTED.

39. PARAGRAPH THIRTY-NINE (39) is ADMITTED.

40. PARAGRAPH FORTY (40) is ADMITTED except it is DENIED that Kevin's brother is in a foster home.

41. PARAGRAPH FORTY-ONE is DENIED.

42. PARAGRAPHS FORTY-TWO (42) and FORTY-THREE (43) are ADMITTED only to the extent that they accurately summarize certain portions of Kevin S's official records at Haverford State Hospital.

44. PARAGRAPH FORTY-FOUR (44) is ADMITTED.

45. PARAGRAPH FORTY-FIVE (45) is DENIED as it is an incomplete and therefore inaccurate reference to certain portions of Kevin S.'s official records at Haverford State Hospital.

46. PARAGRAPH FORTY-SIX (46) is ADMITTED to the extent that it avers that the decision to admit Kevin S. to Haverford was made on July 13, 1977, and that an admission date of July 18, 1977 was established. All remaining averments are DENIED.

47. PARAGRAPH FORTY-SEVEN (47) is ADMITTED.

48. PARAGRAPH FORTY-EIGHT (48) is DENIED as being incomplete and therefore inaccurate.

49. PARAGRAPH FORTY-NINE (49) is DENIED.

50. PARAGRAPH FIFTY (50) is DENIED.

51. PARAGRAPH FIFTY-ONE (51) is DENIED.

52. PARAGRAPH FIFTY-TWO (52) is ADMITTED only to the extent that it accurately summarizes certain portions of Richard S.'s official records at Haverford State Hospital.

53. PARAGRAPH FIFTY-THREE (53) is DENIED.

54.-55. PARAGRAPHS FIFTY-FOUR (54) and FIFTY-FIVE (55) are ADMITTED.

56. PARAGRAPH FIFTY-SIX (56) is DENIED as being incomplete and therefore inaccurate.

57.-58. PARAGRAPHS FIFTY-SEVEN (57) and FIFTY-EIGHT (58) are DENIED.

59. PARAGRAPH FIFTY-NINE (59) is ADMITTED.

60. PARAGRAPH SIXTY (60) is DENIED.

61.-62. PARAGRAPHS SIXTY-ONE (61) and SIXTY-TWO (62) are ADMITTED.

63. PARAGRAPH SIXTY-THREE (63) is DENIED.

64. PARAGRAPH SIXTY-FOUR (64) is ADMITTED only to the extent that it accurately summarizes

certain portions of Richard S.'s official records at Haverford State Hospital.

65. PARAGRAPH SIXTY-FIVE (65) is ADMITTED except that it is DENIED that Edward B.'s psychiatrist is "also a full-time psychiatrist in another unit at Haverford State Hospital".

66.-67. PARAGRAPHS SIXTY-SIX (66) and SIXTY-SEVEN (67) are DENIED as incomplete and therefore inaccurate summaries of certain portions of Edward B.'s official records at Haverford State Hospital.

68.-69. PARAGRAPHS SIXTY-EIGHT (68) and SIXTY-NINE (69) are ADMITTED.

70. PARAGRAPH SEVENTY (70) is DENIED as being incomplete and therefore inaccurate.

71. PARAGRAPH SEVENTY-ONE (71) is DENIED except that it is ADMITTED that paragraphs 84-86 refer to this plaintiff.

72. PARAGRAPH SEVENTY-TWO (72) is ADMITTED except that it is DENIED that Raymond C. was committed by his father to Haverford State Hospital.

73. PARAGRAPH SEVENTY-THREE (73) is ADMITTED.

74. PARAGRAPH SEVENTY-FOUR (74) is DENIED.

75.-76. PARAGRAPHS SEVENTY-FIVE (75) and SEVENTY-SIX (76) are ADMITTED.

77. PARAGRAPH SEVENTY-SEVEN (77) is DENIED.

78.-80. PARAGRAPHS SEVENTY-EIGHT (78) through EIGHTY (80) are ADMITTED.

81. PARAGRAPH EIGHTY-ONE (81) is DENIED as being incomplete and therefore inaccurate.

82. PARAGRAPH EIGHTY-TWO (82) is ADMITTED only to the extent that it accurately summarizes certain portions of William B.'s official records at Haverford State Hospital.

83. PARAGRAPH EIGHTY-THREE (83) is DENIED in that the defendants are without knowledge or information sufficient to form a belief as to the truth of the averments contained therein.

84.-85. PARAGRAPHS EIGHTY-FOUR (84) and EIGHTY-FIVE (85) are DENIED.

86.-87. PARAGRAPHS EIGHTY-SIX (86) and EIGHTY-SEVEN (87) are ADMITTED.

88. PARAGRAPH EIGHTY-EIGHT (88) is DENIED.

89.-90. PARAGRAPHS EIGHTY-NINE (89) and NINETY (90) are ADMITTED only to the extent that they accurately summarize certain portions of Francis B.'s official records at Haverford State Hospital.

91. PARAGRAPH NINETY-ONE (91) is DENIED.

92.-93. PARAGRAPHS NINETY-TWO (92) and NINETY-THREE (93) are ADMITTED.

94. PARAGRAPH NINETY-FOUR (94) is DENIED as being incomplete and therefore inaccurate.

95. PARAGRAPH NINETY-FIVE (95) is ADMITTED.

96.-97. PARAGRAPHS NINETY-SIX (96) and NINETY-SEVEN (97) are ADMITTED only to the extent that they accurately summarize certain portions of Thomas W.'s official records at Haverford State Hospital.

98. PARAGRAPH NINETY-EIGHT (98) is ADMITTED.

99. PARAGRAPH NINETY-NINE (99) is DENIED.

100. PARAGRAPH ONE HUNDRED (100) is DENIED.

101. PARAGRAPH ONE HUNDRED AND ONE (101) is DENIED except that it is ADMITTED that Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge, and that it originated in the first decade of this century and is currently unaccredited by the Joint Commission on Accreditation of Hospitals.

102. PARAGRAPH ONE HUNDRED AND TWO (102) is ADMITTED to the extent that it avers that Polk State School and Hospital is located in the rural community of Polk, Pennsylvania, approximately 80 miles from Pittsburgh and originated in 1897. All remaining averments are DENIED.

103.-116. PARAGRAPHS ONE HUNDRED AND THREE (103) through ONE HUNDRED AND SIXTEEN (116) are ADMITTED only to the extent that they accurately summarize certain portions of the specified plaintiffs' official records at Polk State School and Hospital.

117. PARAGRAPH ONE HUNDRED AND SEVENTEEN (117) is ADMITTED only to the extent that it accurately summarizes certain portions of George S.'s official records at Pennhurst State School and Hospital except that it is denied that Catholic Social Services was granted a "commitment to Pennhurst for a short-term period of 90 days."

118. PARAGRAPH ONE HUNDRED AND EIGHTEEN (118) is DENIED.

119.-120. PARAGRAPHS ONE HUNDRED AND NINETEEN (119) and ONE HUNDRED AND TWENTY (120) are DENIED.

122.-129. PARAGRAPHS ONE HUNDRED AND TWENTY-TWO (122) through ONE HUNDRED AND TWENTY-NINE (129) constitute legal conclusions and therefore require NO RESPONSES.

130. PARAGRAPH ONE HUNDRED AND THIRTY (130) is DENIED.

131. PARAGRAPH ONE HUNDRED AND THIRTY-ONE (131) is ADMITTED.

132.-156. PARAGRAPHS ONE HUNDRED AND THIRTY-TWO (132) through ONE HUNDRED AND FIFTY-SIX (156) constitute legal conclusions and therefore require NO RESPONSE, if however, they should be deemed factual in nature, they are DENIED.

Second Defense

Plaintiffs' claims must be dismissed inasmuch as there is not sufficient "state action" to implicate the Due Process Clause of the Fourteenth Amendment.

Third Defense

Plaintiffs have failed to state a claim for which relief may be granted.

Fourth Defense

This Court lacks jurisdiction over the subject matter of this action.

Fifth Defense

The classes proposed by plaintiff should not be allowed in that juveniles who have been admitted by publice welfare agencies cannot adequately represent those unnamed juveniles who have been admitted by their parent or parents.

Sixth Defense

This case should not be maintained as an action against a class of defendants.

Seventh Defense

Plaintiffs have failed to exhaust adequate statutory remedies available to them under state law.

WHEREFORE, defendants request that the complaint be dismissed and that judgment be entered in their favor.

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
ROBERT B. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

MOTION FOR CLASS ACTION

Plaintiffs, by their attorney and guardian ad litem, hereby move the Court to declare this a class action, pursuant to Rule 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure and to allow it to be maintained on behalf of the following class and subclasses of plaintiffs and against the following class of defendants:

Plaintiff Class and Subclasses:

The members of the class of plaintiffs are all persons who are or who may be committed to institutions for the mentally ill and the mentally retarded in Pennsylvania upon application of parents or guardians and without notice, hearing, counsel and other procedural safeguards.

Subclass A of plaintiffs includes all those persons under 14 years of age committed under Section 201 of the Mental Health Procedures Act of 1976.

Subclass B of plaintiffs consists of all persons 18 years of age or younger committed under Sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966.

Defendant Class:

The defendant class are all directors of all mental health and mental retardation facilities in Pennsylvania, all of which are subject to the challenged statutes and all of which are subject to regulation by the defendant Secretary of Public Welfare.

For the purposes of this motion and the proposed classes, "facilities" refers to those institutions for residential care defined in Section 102 of the Mental Health and Mental Retardation Act of 1966 and in Section 105 of the Mental Health Procedures Act of 1976.

The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (the plaintiffs number in the thousands, the defendants include scores of facility directors); there are questions of law and fact common to the class (see paragraph 13 of Amended and Supplemental Complaint); the claims of the representative parties are typical of the claims of the class (true as to both defendants and plaintiffs); the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

One important word with respect to the class representation and adequacy thereof. The Supreme Court's admonition to this Court that it "stop, look and listen" before certifying a class, noting the state's regulations and the potential distinction between younger and older children, *Kremens v. Bartley*, Slip Opinion at 14-15, should and must be responded to by emphasizing that this case deals with the *minimum* due process required for *all* com-

mitments, of whatever age the child, and whatever the alleged "disability." Thus, the facts of the case require no further counsel or further subclasses for a proper and adequate disposition. The Court might also wish to note that present counsel has properly and competently maintained this action as guardian *ad litem* and the Court might specifically make a finding of no conflict of interest among members of the plaintiff class.

There can be no doubt that a class action is an appropriate vehicle for determination of due process claims of mental patients. *E.g., Meisel v. Kremens,* 405 F. Supp. 1253 (E.D. Pa. 1975) (invalidating summary revocation of mental patients' long term leave); *Goldy v. Beal,* 429 F. Supp. 640 (M.D. Pa. 1976) (Three-Judge Court) (invalidating civil commitment statute); *Bell v. Wayne County General Hospital,* 384 F. Supp. 1085 (E.D. Mich. 1974) (civil commitment); *Lessard v. Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972) (civil commitment); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974).

No further memorandum will be submitted in support of this motion, except at the Court's direction or in response to any filing by the defendants.

For the convenience of the Court, and should the Court not file a memorandum on this issue, plaintiffs have attached a draft proposed order for class action determination.

Respectfully submitted,

(s) David Ferleger

David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103

Certificate of Service

David Ferleger, Esquire, hereby certifies that on the 8th day of November, 1977, he mailed true and correct copies of the foregoing to all counsel for the defendants herein and to counsel for the amici, by U.S. Mail, first class postage pre-paid.

(s) David Ferleger

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

INTERROGATORIES TO THE DEFENDANTS

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, plaintiffs request the defendants to answer, under oath, the following interrogatories:

1. How many juveniles, mentally ill and mentally retarded, were confined in state owned and operated institutions for the mentally ill as of October 31, 1977, (1) under Section 201 of the Mental Health Procedures Act of 1976, (2) under 302, 303, 304 and 305 of that Act, (3) under Sections 402, 403, 405 and 406 of the Mental Health and Mental Retardation Act of 1966. For sections (1) and (2), "juvenile" means a person under 14; for section (3), juvenile means a person between 0 and 18.

2. How many juveniles (defined as a person between 0 and 18) were confined in state owned and operated state schools and hospitals for the retarded as of October 31, 1977, under Sections 402, 403, 405 and 406 of the Mental Health and Mental Retardation Act of 1966.

3. How many juveniles were confined as of October 31, 1977 in licensed facilities in Pennsylvania pursuant to the categories in interrogatory No. 1 and according to the definitions in that interrogatory.

4. For each juvenile identified in interrogatories 1 through 3 above, obtain the identity and nature of relationship of the applicant for admission/commitment, and specify in aggregate form that information (e.g., parent, foster parent, county welfare department, police, other relative, juvenile court official, neighbor).

Please reply within 30 days to David Ferleger, counsel for plaintiffs, at the address below.

(s) David Ferleger
David Ferleger, Esquire
2321 Sansom Street
Philadelphia, Pa. 19103
215-567-2828, 735-8409
Counsel for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' ANSWER TO PLAINTIFFS' INTERROGATORIES

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, Defendants here submit the following Answers to Plaintiffs' Interrogatories.

1. As of October 31, 1977, there were in state-owned and operated institutions for the mentally ill:

100 juveniles under Section 201;
0 juveniles under Section 302;
0 juveniles under Section 303;
8 juveniles under Section 304;
2 juveniles under Section 305;
0 juveniles under Section 402;
0 juveniles under Section 403;
0 juveniles under Section 405;
1 juvenile under Section 406.

2. As of October 31, 1977, there were in state-owned and operated centers for the retarded:

984 juveniles under Section 402;
1 juvenile under Section 403;
0 juveniles under Section 405;
66 juveniles under Section 406.

3. As of October 31, 1977, there were in licensed facilities in Pennsylvania:

juveniles under Section 201;
juveniles under Section 302;
juveniles under Section 303;
juveniles under Section 304;
juveniles under Section 305;
2052 juveniles under Section 402;
3 juveniles under Section 403;
0 juveniles under Section 405;
47 juveniles under Section 406.

4. The juveniles identified in paragraph one through three above were admitted/committed to these institutions by persons or agencies as follows:

2689 by natural parent;
5 by foster parent;
300 by county welfare agencies;
0 by police;
21 by other relatives;
119 by Juvenile Court;
0 by neighbor;
10 by guardian;
120 by others.

Respectfully submitted,
(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
ROBERT B. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, MARGARET UNDERKOFFLER, being duly sworn according to law, hereby depose and say that:

1. The foregoing answer on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information and belief.

(s) Margaret Underkoffler
Margaret Underkoffler

Subscribed and sworn to before me this 8th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, KATHLEEN M. ETZWEILER, being duly sworn according to law, hereby depose and say that:

1. The foregoing answers on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information and belief.

(s) Kathleen M. Etzweiler
Kathleen M. Etzweiler

Subscribed and sworn to before me this 8th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' SUPPLEMENTAL ANSWERS TO PLAINTIFFS' INTERROGATORIES

Pursuant to Rule 33 of the Federal Rules of Civil Procedure, Defendants here submit the following Supplemental Answers to Plaintiffs' Interrogatories. The Supplemental Answers provide information on the number of juveniles in licensed mental health facilities and the manner of their placement, in response to questions three (3) and four (4) of Plaintiffs' Interrogatories.

3. As of October 31, 1977, there were in licensed facilities in Pennsylvania:

250 juveniles under Section 201
0 juveniles under Section 302
0 juveniles under Section 303
0 juveniles under Section 304
0 juveniles under Section 305

4. The juveniles identified in paragraph three (3) above were admitted/committed to these institutions by persons or agencies as follows:

249 by natural parent
0 by foster parent

1 by county welfare agency
0 by police
0 by other relatives
0 by Juvenile Court
0 by neighbor
0 by guardian
0 by others

Respectfully submitted,
(s) Norman J. Watkins
Norman J. Watkins
Deputy Attorney General
Robert B. Hoffman
Assistant Attorney General
J. Justin Blewitt, Jr.
Chief, Civil Litigation
Robert P. Kane
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

I, Margaret Underkoffler, being duly sworn according to law, hereby depose and say that:

1. The foregoing answers on behalf of Defendants to Plaintiffs' Interrogatories are true and correct to the best of my knowledge, information, and belief.

(s) Margaret Underkoffler
Margaret Underkoffler

Subscribed and Sworn to before me this 19th day of December, 1977.

Eva R. Hartman
Notary
Notary Public

My Commission Expires May 13, 1978.
(Seal)

Certificate of Service

AND NOW, this 22nd day of December, 1977, I, Norman J. Watkins, Deputy Attorney General for the Commonwealth of Pennsylvania, counsel for Defendants, hereby certify that on Thursday, December 22, 1977, I served Defendants' Supplemental Answers to Plaintiffs' Interrogatories by depositing said document in the United States Mail, postage prepaid, addressed to:

David Ferleger, Esquire
2321 Sansom Street
Philadelphia, PA 19103

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General

Patients in Public Institutions as of October 31, 1977

	Mental Health Procedures Act of 1976												MH/MR Act of 1966									
	Sections												Sections									
	Ages 0 - 14						Ages 15 - 18						Ages 0 - 14					Ages 15 - 18				
	TOTAL	201	302	303	304	305	TOTAL	201	302	303	304	305	TOTAL	402	403	405	406	TOTAL	402	403	405	406
PPI	11	11																				
mbreeville	0													5					3			1
orristown	0																					
stern State School	40	20			8	2																
ve-ford	10	10																				
iladelphia	0																					
nnhurst																						
odhaven														8			9		18			17
llentown	27	27												49			1		61			5
arks Summit	0																					
rview	0																					
treat	0																					
rnersville	0																					
nburg																						
te Haven														16			3		74			6
ville	0													59			3		51			5
rrisburg	0																					
lidaysburg	0																					
erset	0																					
oona Center																						
sson														30					34			
nsburg														10					34			
relton														24					158			
insgrove														19			1		30			2
mont														10					42			1
view																						
rance	21	21																				
ren	0																					
dville	0																					
ch	1	1																				
k														0	0	0	0		0	0	0	0
tern														52			3		23			1
														29	1		6		85			2

BEST COPY AVAILABLE

Procedures Act of 1976
MH/MR Act of 1966

Juveniles in Public Institutions as of October 31, 1977

Institutionalized Juveniles Admitted/Commited by:

	TOTAL		Parent		Foster Parent		Co. Welfare Dept.		Police		Other Relative		Juvenile Court Official		Neighbor		Guardian		Other (specify)	
	76	66*	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66
EPPI			5				6													
Embreeville				3				5						1						
Norristown																				
Eastern State School			27				2						11							
Haverford			9														1			
Philadelphia														36						
Pennhurst				27				4												
Woodhaven				77				12						6				1		
Allentown			27					1												
Clarks Summit																				
Farview																				
Retreat																				
Wernersville																				
Hamburg				37				2						9				1		
White Haven				78				1?				1								
Danville																				
Harrisburg																				
Hollidaysburg																				
Somerset																				
Altoona Center				59		1		4												
Cresson				41				2				1								
Ebensburg				170				8						2				1		1
Laurelton				44				1				2								5
Selinsgrove				37																16
Dixmont												5	-							
Mayview			16										3							
Torrance																				
Warren																				
Woodville			1																	
March																				
Polk				135										4						
Western			1	109				4				2		8				1		

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' RESPONSE TO PLAINTIFFS' MOTION FOR CLASS ACTION

Defendants hereby respond and object to Plaintiffs' Motion for Class Certification as follows:

1. The factual and legal considerations for children who have been institutionalized at the behest of a public service agency differ significantly from those who are institutionalized by his or her parent(s). Accordingly, it is inappropriate for one group to represent the interests of the other, as has been proposed by the plaintiffs.

2. The case is inappropriate for certification of a defendant class in that the legal and factual considerations with respect to directors of state-owned and operated facilities differ significantly from those involved with respect to directors of private licensed facilities.

3. The proposed defendants are not so numerous as to make joinder impractical as required by F.R.C.P. 23.

WHEREFORE, defendants respectfully request that the plaintiff class be certified only in accordance with Paragraph 1 above. Further, defendants request that the

Court refuse to certify a defendant class for the reasons set forth in Paragraphs 2 and 3 above.

Respectfully submitted,

NORMAN J. WATKINS
Deputy Attorney General
ROBERT P. HOFFMAN
Assistant Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

STIPULATION OF COUNSEL

I. *Stipulation of Facts*

The following facts are stipulated to by and between the plaintiffs and the defendants through their counsel, subject to the objections noted at paragraphs 47 and 48 below:

1. In this action, plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief for violations of their civil rights resulting from the operation of Pennsylvania statutes which permit their indeterminate confinement in institutions for the mentally ill and mentally retarded under color of state law with no right to notice, hearing, counsel and other procedural safeguards. The statutes are challenged on the ground that they conflict with the plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment of the United States Constitution.

2. The defendants are those state officials who accept and receive into custody the named plaintiffs, minors, upon the application of parents or guardians such as welfare departments and child care agencies.

3. This case has been before the Court as *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), vacated and remanded, 96 S.Ct. 1709 (1977). This amended and supplemental complaint substitutes new class representatives and informs the Court of recent state statutory developments.

4. Jurisdiction is asserted under 28 U.S.C. 1331 which provides for original federal question jurisdiction. The amount [claimed] in controversy, exclusive of interests and costs, exceeds $10,000.

5. Jurisdiction is also asserted under 28 U.S.C. 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law.

6. The federal statutes and rules under which plaintiffs' claim relief are 28 U.S.C. 2201, 2202, 2281, 2284, Rules 57 and 65 of the Federal Rules of Civil Procedure (all of which relate to declaratory judgments, injunctions and three-judge courts) and 42 U.S.C. 1983 and 1988 (which relate to civil rights actions).

7. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. 2281 and 2284 since the plaintiffs seek an injunction to restrain defendants, state officials, from the enforcement, execution and operation of portions of state statutes of state-wide applicability on the ground that said statutes are contrary to the United States Constitution. This action was filed prior to the enactment of Public Law 94-381 which amended the three-judge court statutes.

8. The named plaintiffs bring this action in their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

9. The questions of law and fact involved are:

a. Are the representative plaintiff parties, and their class members admitted/committed to mental institutions pursuant to the challenged statutes and without notice, counsel, hearing and other procedural safeguards?

b. Do the defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process Clause of the Fourteenth Amendment to the United States Constitution?

10. The named plaintiffs sue by their next friend and guardian ad litem, appointed by the Court pursuant to Rule 17 of the Federal Rules of Civil Procedure.

11. The parties agree that the named plaintiffs may be designated by their actual given names and the initial of their surnames. Their full identities have been made known to the defendants.

12. The first group of plaintiffs, those confined at Haverford State Hospital, under the Mental Health Procedures Act of 1976, are all the juveniles under 14 years of age admitted/committed under Section 201 as of October 31, 1977, to that institution.

13. The second group of plaintiffs are persons with mental retardation confined under the Mental Health and Mental Retardation Act of 1966, Sections 402 and

403, in two institutions, one near Philadelphia in the eastern part of Pennsylvania and one near Pittsburgh in the west.

First Group of Plaintiffs; Those at Haverford State Hospital

14. Plaintiff Kevin S., born May 2, 1965, is a citizen of Pennsylvania. He is 12 years old.

15. Plaintiff Richard S. is now 13 years old and a citizen of Pennsylvania. He was born September 24, 1964.

16. Plaintiff James Paul M. is 7 years old, having been born on November 10, 1969. He is a citizen of Pennsylvania.

17. Plaintiff Raymond C. was born on September 9, 1964, is a citizen of Pennsylvania, and is 13 years old.

18. Plaintiff William B. was born June 18, 1968, is 9 years old and is a citizen of Pennsylvania.

19. Plaintiff Eddie B. was born October 26, 1965, is a citizen of Pennsylvania, and is 12 years old.

20. Plaintiff Francis B. was born January 9, 1967, is 10 years old and a citizen of Pennsylvania.

21. Maria L., plaintiff in this action, was born August 26, 1965, is 12 years old and a citizen of Pennsylvania.

22. Thomas W., born February 14, 1966, is 11 years old and a citizen of Pennsylvania.

Second Group of Plaintiffs; Those at Polk and Pennhurst State School and Hospitals

23. Plaintiff Nancy Louise D., born December 10, 1960, is a 16 year old citizen of Pennsylvania.

24. Plaintiff Gina S. was born on July 30, 1961, and is a citizen of Pennsylvania. She is 16 years of age.

25. Plaintiff George S. was born February 10, 1963, is 14 years old, and is a citizen of Pennsylvania.

Defendants

26. Defendant Secretary of Public Welfare is the Pennsylvania state official who, in that capacity, has the power and duty to enforce the challenged statutes and all regulations necessary and appropriate to the proper accomplishment of those provisions and "to operate and assign functions to all State facilities." See Sections 201 (2) and 202 (a) of the Mental Health and Mental Retardation Act of 1966, and Section 105 of the Mental Health Procedures Act of 1976 ("Treatment Facilities"), and 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility"). Aldo Colautti currently occupies that office; Frank Beal, who was Secretary at the time this action was filed, left office on February 15, 1978.

27. Defendant John Fong is the director of Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4102, 4203 and 4417. It is to Fong or his delegate that applications for admission, commitment or release of the plaintiffs must be made. Under Section 202 of the 1976 Act, application for examination and treatment may also be made to the county mental health/mental retardation administrator who designates an approved facility for examination and for such treatment as may be appropriate. Haverford State Hospital is an approved facility under Section 105 of the Mental Health Procedures Act of 1976.

28. Defendants Nicholas D'Aluisio and C. Duane Youngberg are, respectively, directors of the Polk State School and Hospital and the Pennhurst State School and Hospital, both institutions for persons with mental retardation. They are charged with supervision and administration of those facilities. See Sections 102, 203 and 417 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. 4102, 4203 and 4417. It is to D'Aluisio, Youngberg or their delegates that applications for admission, commitment or release of the plaintiffs must be made. See sections 402(b), 403(b) and 403(c) of the Mental Health and Mental Retardation Act of 1966.

Haverford State Hospital

29. Haverford State Hospital is an institution for the mentally ill located in a rural/suburban area outside Philadelphia.

30. The institution's score of buildings cover a large hilly area in one corner of which is Building 14, a building with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles.

31. As of October 31, 1977, there were a total of 12 juveniles in the Children's Unit in Building 14. Three were committed by juvenile courts, after hearings; 9 were admitted/committed under the challenged statutes, upon application to the institution by parents or guardians.

32. Entry into the Children's Unit in Building 14 is through a door that is kept locked. When a buzzer is rung, a worker inside comes to unlock the door. The door bears a sign which reads, "VISITING HOURS—1:30-4:30 Weekends and Holidays. No evening visits. (signed) Dr. Bernard Kanter."

33. The Unit consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two carpeted unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory area for female patients.

34. (Modified orally) In the nursing station is a bank of television monitors which are used to surveil the patients in all areas of the Unit, including the halls and dormitories.

35. Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high.

36. Dr. Carl Hammer is a part-time psychiatrist in a unit other than the Children's Unit at Haverford State Hospital.

37. All mental health and mental retardation facilities in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare. As part of the approval/licensing, such facilities have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act.

38. Since the effective date of the 1976 Act, the regulations adopted by the Department of Public Welfare in 1973 (reproduced at 786a, footnote 5 of the July 24, 1975 Opinion of the District Court) are used by the defendants and apply only to juveniles admitted/committed as mentally retarded under Sections 402 and 403 of the 1966 Act. The regulations do not apply to juveniles ad-

mitted/committed as mentally ill under Section 201 of the 1976 Act.

39. Except as may be provided in the 1973 regulations referred to above, when institutionalized juveniles object to their confinement or express a desire to leave the institution, as the named plaintiffs have through their guardian ad litem and as some have done personally, the defendants do not provide counsel or take action to assure either discharge or a hearing on the juvenile's objections because the defendants believe, as a matter of law, that they are not required to do so.

II. EVIDENCE

40. The evidence which was admitted in the initial proceeding, including all testimony, depositions, exhibits, interrogatories, objections and rulings shall be deemed included in the record in these proceedings. Further, for the convenience of the parties and the Court, the printed Appendix, which was used in the Supreme Court, No. 75-1064, with permission of this Court shall be used in these proceedings.

41. As used in this stipulation, the following terms have the following meanings and references:

a. "Juveniles" mean persons 18 years of age or younger admitted/committed under Sections 402-3 and 405-6 of the Mental Health and Mental Retardation Act of 1966, and those persons under 14 years of age admitted/committed under Sections 201, 302-5 of the Mental Health Procedures Act of 1976.

b. "Mental Health and Mental Retardation Act of 1966", "MH/MR Act of 1966", "1966 Act" and "66" refer to 50 P.S. §4101 et seq.

c. "Mental Health Procedures Act of 1976", "MHP Act of 1976", "1976 Act" and "76" refer to 50 P.S. §7101 et seq.

d. Sections 201, 302, 303, 304 and 305 refer to the corresponding sections of the 1976 Act.

e. Sections 402, 403, 405 and 406 refer to the corresponding sections of the 1966 Act.

f. "Licensed mental health facilities" refers to those residential mental institutions not operated by the State and which are licensed or approved by the Department of Public Welfare to provide mental health and retardation services. See Section 102, 201, 202(a), 203 and 417 of the 1966 Act; Section 105 of the 1976 Act (this section applies as well to state operated mental institutions); 6 Pa. Bull. 2115 at Section 7100.1.2 (definition of "approved facility").

42. The Defendants' Answer to Plaintiffs' Interrogatories attached as Exhibit A hereto, and the Defendants' Supplemental Answers to Plaintiffs' Interrogatories, attached as Exhibit B hereto, indicate the number of persons in Pennsylvania admitted/committed under the challenged statutes and the applicants for their admission/commitment as of October 31, 1977. The information referred to in paragraphs 42, 43, and 44 is substantially accurate at this date.

43. Exhibit C is a table indicating, for all juveniles in state-owned and operated institutions, the age ranges and statutory provisions under which they were admitted/committed, by institution.

44. Exhibit D is a table indicating all juveniles in state-owned and operated institutions, by institution, and indicating the identity and nature of relationship of the

applicant for admission/commitment by various specified categories.

45. Of the 119 juveniles listed in Exhibit A, paragraph 4, as having been admitted/committed by "Juvenile Court", 114 were committed by the Court under Section 406 and 5 were admitted/committed by the Court under Section 201.

46. Defendants have not been precluded from offering any additional evidence over and above that which has been offered and admitted or excluded by a specific order of this court. The same is true of plaintiffs. [Further offers of proof may be made at the hearing of this matter.]

III. OBJECTIONS

47. Defendants object to the admission of the facts stipulated at paragraphs 29, 30, 32, and 36 above on grounds of relevance and on the basis that they [fail to provide a complete or accurate depiction of Haverford State Hospital.]

48. Plaintiffs object to the admission of Part A of the Exhibits 1 through 12, described below, on two grounds: first, their relevance because they are preadmission material, and second, that [some portions] of this material [were] not received by the institution until some time after the admission/commitment process was concluded.

IV. RECORDS OF NAMED PLAINTIFFS

49. Exhibits 1 through 12 which are to be submitted into evidence are portions of the official records of the named plaintiffs at their respective institutions, referred to as "the Records Exhibits".

50. Each of the "Records Exhibits" includes a Part A and a Part B.

51. Part A is pre-admission material including such things as background referral material, school and outpatient records. It is specifically noted by the parties that there is no stipulation that all of the material in Part A was received by the institution prior to the completion of the admission process.

52. Part B on Haverford State Hospital patients consists of the institution's Admission Note.

Psychosocial history, psychological evaluation and a New Case Conference note, all developed shortly after admission/commitment. Part B also includes the statutory admission/commitment forms. For plaintiffs at Polk and Pennhurst, Part B consists of the reports of various examinations conducted shortly after admission. Part B also includes the statutory admission/commitment forms.

53. The parties will finalize and present to the Court at the March 31, 1978 hearing the contents of Exhibits 1 through 12.

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ESQUIRE
ROBERT B. HOFFMAN,
ESQUIRE
Department of Justice
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Harrisburg, PA 17120
Attorneys for Defendants
DAVID FERLEGER, ESQUIRE
2321 Sansom Street
Philadelphia, PA 19103
Attorney for Plaintiffs

Exhibit C

Juveniles in Public Institutions as of October 31, 1977

	Mental Health Procedures Act of 1976												MH/MR Act of 1966									
	Sections												Sections									
	Ages 0 - 14						Ages 15 - 18						Ages 0 - 14					Ages 15 - 18				
	TOTAL	201	302	303	304	305	TOTAL	201	302	303	304	305	TOTAL	402	403	405	406	TOTAL	402	403	405	406
EPPI	11	11																				
Embreeville	0													5					3			1
Norristown	0																					
Eastern State School	40	30			8	2																
Haverford	10	10																				
Philadelphia	0																					
Pennhurst														8			9		18			17
Woodhaven														49			1		61			5
Allentown	27	27																				
Clarks Summit	0																					
Farview	0																					
Retreat	0																					
Wernersville	0																					
Hamburg														16			3		74			6
White Haven														59			3		51			5
Danville	0																					
Harrisburg	0																					
Hollidaysburg	0																					
Somerset	0																					
Altoona Center														30					34			
Cresson														10					34			
Ebensburg														24					158			
Laurelton														19			1		30			2
Selinsgrove														10					42			1
Dixmont																						
Mayview	21	21																				
Torrance	0																					
Warren	0																					
Woodville	1	1																				
March														0	0	0	0		0	0	0	0
Polk														52			3		83			1
Western														29	1		6		85			2

Procedures Act of 1976
MH/MR Act of 1966

D 1944

Juvenile in Public Institutions as of October 31, 1977

Institutionalized Juveniles Admitted/Commited by:

	TOTAL		Parent		Foster Parent		Co. Welfare Dept.		Police		Other Relative		Juvenile Court Official		Neighbor		Guardian		Other (specify)	
	76	66*	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66	76	66
EPPI			5				6													
Embreeville				3				5						1						
Norristown																				
Eastern State School			27				2						11							
Haverford			9														1			
Philadelphia														36						
Pennhurst				27				4												
Woodhaven				97				12						6				1		
Allentown			27					1												
Clarks Summit																				
Farview																				
Retreat																				
Wernersville																				
Hamburg				37				2						9				1		
White Haven				98				19				1								
Danville																				
Harrisburg																				
Hollidaysburg																				
Somerset																				
Altoona Center				59		1		4												
Cresson				41				2				1								
Ebensburg				170				8						2				1		1
Laurelton				44				1				2								5
Selinsgrove				37								5	-							16
Dixmont													3							
Mayview			16																	
Torrance																				
Warren																				
Woodville			1																	
March																				
Polk				135										4						
Western			1	108				4				2		8				1		

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

ORDER

The parties to the above-captioned matter have requested that we rule on two preliminary evidentiary matters in order to facilitate the process of stipulating to facts prior to the hearing. NOW, March 10, 1978, upon consideration of the memoranda of law submitted by the parties, IT IS ORDERED:

1. The findings of fact and conclusions of law contained in *Halderman v. Pennhurst State School and Hospital,* Civil Action No. 74-1345 (E.D. Pa., Dec. 23, 1977), are inadmissible on grounds of relevance. However, evidence generally relating to the deprivation of liberty inherent in confinement in institutions and exposure to institutional environment is admissible.

2. Portions of the plaintiffs' medical records relating to the process of admission to the institutions are relevant and admissible. The remaining portions of the medical records are not relevant to this action and are therefore not admissible.

Judge John J. Gibbons and Judge Raymond J. Broderick have advised me by telephone that they agree with the contents of this Order.

Daniel H. Huyett,
J.
3/13/78

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

MEMORANDUM AND ORDER CERTIFYING DEFENDANT CLASS

HUYETT, J., March 28, 1978:

Plaintiff has moved for certification of both plaintiff and defendant classes pursuant to F.R.C.P. 23. The proposed defendant class is defined as "directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare." Representatives of the class are the Secretary of Public Welfare and directors of three state-owned and operated facilities. Plaintiffs propose that this class be certified pursuant to F.R.C.P. 23(a) and 23(b)(1)(B) or 23(b)(2).

Although we are, at this point, reserving our decision on certification of a plaintiff class, we see no reason to delay certification of a defendant class. For the reasons stated below, we certify the defendant class as defined by plaintiff.

Two of the requirements of Rule 23(a), numerosity and the existence of common questions of law and fact, clearly are met. With respect to numerosity, there are 30 state-owned and operated institutions in Pennsylvania and more than 400 state-licensed facilities. The question of law common to all of these defendants is the validity of the challenged state statutes and regulations governing voluntary commitment of mentally ill and mentally retarded juveniles.

The most important area of inquiry when considering the propriety of a defendant class is to assure that the class representatives will adequately represent the interests of the absent class members. This is assured by requiring that the interests of the class representative be typical of those of absent class members, that the class be conflict-free, and that the class representative have a personal interest in the issues so that the defense mounted will be vigorous. *Note, Defendant Class Actions,* 91 Harv. L. Rev. 630, 639-40 (1978).

Those requirements are met here. The Secretary of Public Welfare, the named class defendant, has a strong interest in defending the validity of the challenged statutes and regulations. In *Commonwealth v. Rizzo,* 530 F. 2d 501 (3d Cir. 1976), the Third Circuit, in discussing the adequacy of representation problem in the context of a motion to intervene as of right, stated:

> [A] presumption of adequate representation arises when the representative is a governmental body or officer charged by law with representing the interests of the absentee. . . . Where official policies and practices are challenged, it seems unlikely that anyone could be better situated to defend than the governmental department involved and its officers.

Id. at 505. *See Pennsylvania Ass'n. for Retarded Children v. Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972).

The same could be said here. The Secretary of Public Welfare is charged with enforcing the statutes and regulations being challenged by the instant lawsuit. Furthermore, we see no possible conflict within the class, since the challenged statutes and regulations are applicable to all of Pennsylvania's mental health institutions, whether state-owned and operated, or privately owned. Thus, we conclude that the Secretary of Public Welfare is an adequate representative of the class.

In conclusion, we certify pursuant to F.R.C.P. 23(a), and 23(b)(2)[1] the following class:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

Since this is a 23(b)(2) class, no notice need be given to absent class members.

Honorable John J. Gibbons and Honorable Raymond J. Broderick advise me that they are in accord with this Memorandum and Order and authorize me to issue the Memorandum and Order on behalf of the three judge court.

Daniel H. Huyett,
J.

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[1] The defendant class also qualifies for certification pursuant to F.R.C.P. 23(b)(1)(B). In view of the binding effect of the statute and the Department of Public Welfare's regulations on all mental health and retardation facilities, "adjudication with respect to individual members of the class . . . would as a practical matter be dispositive of the interests of the other members not parties to the adjudications."

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

ORDER

NOW, March 28, 1978, upon consideration of plaintiffs' motion for certification of a defendant class, and for the reasons stated in the accompanying memorandum, IT IS ORDERED that the plaintiffs' motion is GRANTED. The defendant class is defined as

> The directors of all mental health and retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

Daniel H. Huyett,
J.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

OFFER OF PROOF AND REQUEST FOR EVIDENTIARY RULING

In its opinion remanding this case, the Supreme Court noted that this Court could consider in any further proceedings possible differing considerations which exist between the young and very young and between those persons alleged to be mentally ill and retarded. 431 U.S. 119, 135.

Plaintiffs hereby offer to present expert testimony and factual testimony to the effect that—for the purposes of the minimum due process safeguards declared by the Court in its 1975 Opinion and sought by the plaintiffs now—there are no relevant differences between the mentally ill and the retarded or among juveniles of all ages.

Plaintiffs believe that such evidence (to the extent to which it would not be redundant) is unnecessary and irrelevant and that, as a matter of constitutional law, the minimum due process procedures are the same for all plaintiffs, although, of course, some subgroups might be entitled to a greater amount not at issue in this case.

However, should the Court wish to hear such evidence and find it relevant, plaintiffs will prepare and present it in whatever manner the Court directs.

(s) David Ferleger
David Ferleger, Esquire
Attorney and Guardian Ad Litem for Plaintiffs

CERTIFICATE OF SERVICE

David Ferleger, Esquire, hereby certifies that on the 31st day of March, 1978, he served a true and correct copy of the foregoing Offer of Proof and Request for Evidentiary Ruling upon the counsel for defendants, Norman J. Watkins, in open court.

David Ferleger

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

DEFENDANTS' SUPPLEMENTAL MEMORANDUM

I. *Introduction*

On March 31, 1978, the final hearing was held in this matter. However, several points arose on which the court requested additional briefing.[1] Specifically, the defendants were requested to address the relevance of Part A[2] of the individual plaintiffs' hospital records and the question of what type of hearing should be ordered if one is required.

II. *Relevance of Part A of the Individual Plaintiffs' Hospital Records*

Professor Moore has noted that the test of relevance ". . . depends mainly upon logic . . ." 10 Moore's Federal Practice ¶400.01, at IV-2 (3rd Ed. 1976). Thus the

[1] Both plaintiffs and defendants filed comprehensive pre-trial briefs covering all of the major issues.

[2] These hospital records were separated into Parts "A", "B", and "C". Part "A" concerns all pre-admission material. Part "B" covers records from and including the actual admission note through the first staff conference regarding the patient. Part "B" has been accepted into evidence without objection. Finally, Part "C" of these contained all of the treatment records—however, these were excluded by the court (Order, 3-13-78).

vagueries of the definition of relevance provided in the rules[3] must be resolved logically. While the admissibility provisions of Rule 43(a) have now been superseded by the Federal Rules of Evidence, cases decided under Rule 43 are still instructive for the concept of relevance has not changed significantly. 10 Moore's Federal Practice §400.01 at IV-4 (3rd Ed. 1976). And these cases counsel that the contested records are indeed relevant and therefore admissible.[4]

Initially, it should be noted that the decisions are uniform in favoring admissibility over exclusion on relevance grounds. *Caton v. Hardamon,* 496 F.2d 6 (7th Cir. 1974); *Hasson v. Stafford,* 472 F.2d 88 (3rd Cir. 1973); *Courtland v. Walston & Co.,* 340 F. Supp. 1076 (S.D. N.Y. 1972). Thus, if there is doubt regarding the relevance of a particular piece of evidence, it should be admitted. *United States v. Lykes Bros. Steamship Co.,* 432 F.2d 1076 (5th Cir. 1970); 10 Moore's Federal Practice §400.12[2] at IV-18 (3rd Ed. 1976).

Defendants offered the entire file for each plaintiff for several reasons. The first and foremost of these was to insure that the court has the whole picture. The fact that plaintiffs have repeatedly excerpted portions of these records in their complaint[5] highlights their relevance to

[3] Rule 401 provides:

"Relevant evidence" means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. Fed. R. Evid. 401.

[4] Plaintiffs' sole objection to these records is on grounds of relevance.

[5] See e.g. Paragraphs 39-40, 42, 44, 51-54, 66-67, and 73-74 of the complaint.

this action. Plaintiffs have used portions of these very records to prove their claim—surely the defendants may use the remainder as defense.

Under the rules it is clear that background material such as this should be admitted. Thus, even if the excerpts from the records were not in controversy—further background material tending to clarify the issue is certainly relevant to the action. 10 Moore's Federal Practice §401.06[2] at IV-§1 (3rd Ed. 1976). In fact, this Court's Order dated March 13, 1978, explicitly recognizes the relevance of evidence concerning the admission process, which of course, is the sum and substance of this material. This material is necessary to accurately show what the admission process was for each of the plaintiffs. Inasmuch as it is this very process which the plaintiffs claim violates the Constitution, the relevance of these records is clear beyond peradventure. These records, substantially all of which were possessed by the defendants prior to the actual admission,[6] demonstrate the care and scrutiny given to each case prior to admission.

Finally, the attached affidavits emphatically underscore the relevance of these records. Substantially, all of these materials were in the hands of the admitting facility's staff prior to admission, and those few that weren't related to evaluations and the like that preceded the admission. These records, to a great extent, reflect the professional bases of the recommendation for inpatient care—which recommendation the plaintiffs so vigorously attack. Thus, on the basis of the foregoing, it is strongly urged that these records are relevant to this matter, and should be admitted as evidence.

[6] See affidavits of Ellen N. Lynch, Marcia Murtagh and Mary Thompson, which are attached, regarding the plaintiffs at Haverford State Hospital. Regarding the three mentally retarded plaintiffs—Nancy Louise D., Gina S. and George S.—cover letters in the records reflect that all of that material was received prior to admission.

II. TYPE OF HEARING

At the outset defendants reassert their position that nothing in addition to that which is presently provided by state law in the way of due process in the admission process for children is mandated by the Fourteenth Amendment. Nevertheless, and on the assumption that this Court finds the present scheme wanting in that regard, defendants recommend the following elements be considered:

(a) any hearing procedure should be nonjudicial, taking place before one or more professionals in the field.

(b) Counsel should not be mandatory.

(c) the hearing should be informal, and not of record.

(d) the normal administrative appellate process should be utilized. 71 Pa. Stat. Ann. 1710.41.

(e) the hearing should not be required to be pre-admission, but rather within a reasonable time thereafter.

As the foregoing makes clear, the defendants strongly urge that imposition of a rigid adversary juidicial pre-commitment hearing would indeed be counter-productive. To the extent the due process clause may apply in the admission of a child to a mental health facility—the process

due should be administrative and informal. See *Board of Curators v. Horowitz,* U.S. , 46 U.S.L.W. 4179 (March 1, 1978).

(s) Norman J. Watkins
NORMAN J. WATKINS
Deputy Attorney General
J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation
ROBERT P. KANE
Attorney General

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

MARY THOMPSON, being duly sworn in accordance with law, does state and affirm as follows:

1. I am a Psychological Associate III and work part-time as a staff psychologist in the Children's Unit, Haverford State Hospital. I have worked at Haverford State for approximately 11 years and have worked in the Children's Unit since December 1976.

2. In that capacity, I provide psychological services to patients and review prior to admission psychological

examinations submitted by the referring agency to insure their accuracy and timeliness.

3. Part A of the records of Raymond C. (Defendants' Exhibit 5) includes a two page psychological report prepared by Anthony J. Mannino, District Psychologist on March 8, 1977.

4. Attached to that report is a note handwritten by me stating "Attached Psychological from Leedum School (3/77) will serve as psychological requirement for this hospitalization."

5. My note is undated and I am uncertain of the precise date on which it was written or on which the psychological report was received.

6. Based upon policies and procedures in the Children's Unit, which requires a report of a psychological examination to be submitted prior to a voluntary admission, I am certain that the report was received and my note written prior to admission.

7. The information set forth above is true and correct to the best of my knowledge, information and belief.

(s) Mary W. Thompson
Mary Thompson

Subscribed and sworn to before me this 11th day of April, 1978.

Mary C. Jarrell
Notary
[Notary Stamp Illegible]

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

AFFIDAVIT

MARCIA MURTAGH, M.S.S., being duly sworn in accordance with law, does state and affirm as follows:

1. I am the Chief Social Worker in the Children's Unit at Haverford State Hospital and have served in that capacity since May 9, 1977.

2. Prior to that, I was a Social Worker at Embreeville State Hospital.

3. In my present capacity, I serve as a member of the treatment team for patients in the Children's Unit and am involved in the admission process for many of them.

4. I am familiar with all of the nine (9) plaintiffs who were, as of October 31, 1977, patients in the Unit.

5. I was directly involved in the admission of Raymond C., James Paul M., Kevin S., and Richard S., Defendants' Exhibits 6, 7, and 8 respectively.

6. I have reviewed the material contained in Part A of the records presented to the Court regarding these three patients to determine which particular records were received by the Children's Unit prior to the child's admission. In doing this, I have reviewed correspondence from referring agencies not presently included in Part A

and my own independent recollection of the admission processes of these three children. Based upon them, I am able to state with certainty, as described individually below, which records were received prior to admission.

James Paul M. (Defendants' Exhibit 6)

7. James Paul M. was seen in a pre-admission interview on October 14, 1977 and admitted October 17, 1977.

8. All material included in Part A of his records was sent to me by letter of August 30, 1977 from Mr. Francis Baird, Life Guidances Services (Base Service Unit II). A copy of that letter, not presently in Part A, is attached hereto as Exhibit A.

Kevin S. (Defendants' Exhibit 7)

9. Kevin S. was seen in a pre-admission interview on July 13, 1977 and was admitted July 18, 1977.

10. Psychological and Psychiatric Evaluations in Part A were received by Mrs. Ellen Lynch, by letter of June 30, 1977, from Mrs. Virginia C. Long, Director of Special Education, William Penn School District. This letter is presently included in Part A.

11. All other material in Part A including records from Delaware County Child Care and Base Service Unit II were received prior to pre-admission, according to the pre-admission note prepared by me on July 13, 1977, although I am uncertain of the precise date.

Richard S. (Defendants' Exhibit 8)

12. Richard S. was seen in a pre-admission interview on June 1, 1977 and admitted June 6, 1977.

13. Certain materials in Part A pre-dating January 12, 1977, were received by Mrs. Lynch, attached to a letter of that date from Luana C. Goodwin, Child Care Services. See Affidavit of Ellen Lynch.

14. Additional material in Part A, prepared by Silver Springs-Martin Luther School subsequent to January 12, 1977, were also received prior to the pre-admission interview of June 1, 1977.

15. Although I am uncertain of the precise date on which this material was received, I recall having seen and reviewed this material shortly after I began work in the Children's Unit on May 9, 1977.

16. The only document in Part A which was not received prior to admission is a one page, handwritten School Report dated June 15, 1977.

Raymond C. (Defendants' Exhibit 5)

17. Raymond C. was seen in a pre-admission interview on September 28, 1977.

18. In addition to those records in Part A received by Mrs. Lynch prior to admission, records from Delaware County Court, Juvenile Division were sent to me attached to a letter of September 14, 1977, from Janet Smith, Intake Officer. A copy of that letter, not presently included in Part A, is attached hereto as Exhibit B.

Tom W. (Defendants' Exhibit 12)

19. I was not involved in the actual admission of Tom W., which occurred on June 2, 1977.

20. On June 6, 1977, however, I received from Mr. Lutz, Child Care Services, all documents in Part A other

than those identified as having been received prior to admission in the Affidavit of Ellen Lynch.

21. The information set forth above is true and correct to the best of my knowledge, information, and belief, and the letters attached as Exhibits A and B are true and correct copies of official records at the Children's Unit.

(s) Marcia Murtagh, M.S.S.
Marcia Murtagh, M.S.S.

Subscribed and sworn to before me this 11th day of April, 1978.

Mary C. Jarrell
Notary
[Notarial Stamp Illegible]

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA

Case No. 72-2272

Institutionalized Juveniles, et al.

vs.

Secretary of Public Welfare, et al.

DEPOSITION of LINDA L. GLENN, a witness called on behalf of the Plaintiffs, taken pursuant to notice before Cindy Marie Hansen, a Notary Public in and for the Commonwealth of Massachusetts at 190 Portland Street, Boston, Massachusetts on April 7, 1978, at 4:00 p.m.

Appearances:

David Ferleger, Esquire, 2321 Sansom Street, Philadelphia, Pennsylvania, on behalf of the Plaintiffs.

Robert B. Hoffman, Esquire, Deputy Attorney General, Department of Justice, on behalf of the Defendants.

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(2) STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the reading and signing of the deposition by the witness be waived.

LINDA L. GLENN, a witness called on behalf of the plaintiffs, first having been duly sworn, on oath deposes and says as follows:

Direct Examination

BY MR. FERLEGER:

Q. Miss Glenn, what is your current occupation?

A. Assistant Commissioner for Mental Retardation for the Department of Mental Health, Commonwealth of Massachusetts.

Q. And are you the administrative head of Mental Retardation in Massachusetts?

A. Yes.

Q. So the Assistant Commissioner title involves a commissioner who covers more than Mental Retardation?

A. Right, the Commissioner of Mental Retardation, Mental Health, Drugs, Childrens Services, whole thing, under the commissioner as an Assistant Commissioner for each program area.

(3) Mr. FERLEGER: I'd like to have this marked as Exhibit A, Vita.

(Exhibit A, for identification, VITA of Linda L. Glenn.)

Q. (By Mr. Ferleger) I'm showing you Exhibit A. Can you identify that for the record, please?

A. This is my resume, March of '77. It is not totally up to date.

Q. As of that date, does this resume reflect generally your employment and experience in the area of mental retardation?

A. Yes, it does.

Q. Could you just briefly review that for us, your general employment and experience and we'll let the resume speak for the details?

A. Yes, okay. You want educational experience, or just employment—

Q. Yes.

A. I have a Masters in Special Education for the mentally retarded, a Doctorate without dissertation completed, everything else is completed in educational administration and business administration. I have worked about ten years in the field of mental retardation, first full time after part-time jobs while in school was the (4) Director of Research and Management for the Greater Omaha Association for Retarded Citizens. There I helped develop one of the first comprehensive community-based agency for the mentally retarded. Second full time job was the same position, Director of Research and Management for the Eastern Nebraska Community Office of Retardation, which was an agency that grew out of the Greater Omaha Association, a larger five-county comprehensive program for the mentally retarded, and all of Eastern Nebraska.

I returned to school and worked as a co-Director of Technical Assistance Unit attached to the University of Kansas and the University Affiliated Facility at the University of Kansas which provided technical assistance to all programs in Kansas that served the mentally retarded, all the community programs as well as institutional programs.

Q. When you returned to school, you didn't mean as a student?

A. No, I was a student in a doctoral program there and working as a co-Director on the Technical Assistance

Project. From there, in 1974, I became the Director, Executive Director of the Eastern Nebraska Community Office of Retardation back in Omaha again.

(5) In 1976, I came here to Massachusetts to become Assistant Commissioner.

Q. Could you describe your general duties and responsibilities in your present position?

A. I am responsible for the development and operation of all programs that are sponsored by or funded by the Commonwealth of Massachusetts for the mentally retarded. This includes eight large state operated facilities for the mentally retarded; it includes a system of community programs that are operated by 40 area offices that are part of seven regions. We have the state divided into, that is, developing into a comprehensive system of community residential programs and have a variety of different types, so individuals can move along and continue services, day programs for adults, sheltered workshops, activity centers, early intervention programs, respite care programs, and other support services for the mentally retarded.

The responsibilities include, well, the objectives are to not only develop comprehensive community programs at each of the areas for any mentally retarded person who needs service, but also returning people from the institutions of the state to those community programs.

(6) In addition, I have responsibility for licensing all programs, private or public, that are for the mentally retarded, and for insuring compliance in all the institutional services to Federal regulations.

Q. What is the approximate budget of your office, the Division of Mental Retardation.

A. This year, it is a little over $100 million.

Q. Are you familiar with or do you have any experience with mental retardation and mental retardation administrative systems in other states besides Nebraska and Massachusetts?

A. Yes, I do.

Q. What way have you gained that background?

A. I've consulted with many other states in various categories or various reasons, both state-wide planning efforts, local planning efforts, the development of systems to get people out of institutions, the development of comprehensive systems of community services, technical assistance as well as involvement in those plans. I'm a member of the Willowbrook Review Panel, appointed Page which oversees the Department of Mental Hygienes activities in the state of New York relative to their consents agreement for Willowbrook institution which effects the entire state of New York. The class members from that 5,300-bed institution are now in almost every facility in (7) the state, so we oversee the services in that state.

I have been a consultant for several years for the National Institute on Mental Retardation in Toronto and helped them devise systems in Canada for the development of programs.

Q. And in the states that you referred to and mentioned in your resume, have you visited institutions and community facilities for the retarded in those areas?

A. Yes.

Q. Would that include Pennsylvania as well?

A. Yes.

Q. You visited community facilities in Pennsylvania?

A. Yes, I've done a lot of work in Pennsylvania. In fact, one of the things that brought me in contact with

a lot of institutions as well as a lot of community programs is I helped devise an evaluation system used widely now throughout Canada and the United States, and in the six years of development of that system, we've evaluated, and I personally evaluated, hundreds of different programs to refine that instrument as an evaluation tool.

Q. That is—off the record.

(An off-the-record discussion was held.)

Q. (By Mr. Ferleger) That's the PASS system?

(8) A. Yes, it stands for the Program and Analysis of Services Systems and I have evaluated quite a few services in Pennsylvania on that system. In fact, they use it widely. I trained, I had three different week-long training workshops in Pennsylvania several years ago to train all the Pennsylvania staff.

Q. The Department of Public Welfare in Pennsylvania uses that PASS System?

A. Yes, they do.

Q. Do they use it to evaluate facilities for the retarded in Pennsylvania?

A. Community residential programs, right, yeah.

MR. FERLEGER: Mr. Hoffman, we would submit that Linda Glenn is qualified as an expert in the area of mental retardation, care and rehabilitation of retardation institutions and community care for the retarded in the United States. Do you have any objections to her qualifications?

MR. HOFFMAN: Without admitting all those areas are necessarily relevant to this court case, I would certainly agree she qualifies as an expert in those areas.

Q. (By Mr. Ferleger) Miss Glenn, could you tell us please generally who are the mentally retarded

in the United (9) States? What kind of people are they, how many are there, just what kind of people are we talking about?

A. The commonly used prevalence rate for how many people are mentally retarded in the United States is about 3 percent. That is, that has been used historically from some incident studies, prevalence studies done years ago and it still has not been challenged. Three percent, I guess, of the population of the United States right now would be two or three million people, so you are talking about a very large number of people. That 3 percent, however, is made up of a variety of needs of individuals and severe levels of retardation. The large bulk within that 3 percent are the more moderately handicapped persons.

Q. How many is that large bulk?

A. Oh, at least 80 to 85 percent of the mentally retarded are more mildly handicapped persons that don't need a lot of special services. They can live in the community typically without anybody knowing they were mentally retarded unless somehow in some system they've gotten labeled or institutionalized for some reason. Only about 5 percent of the mentally retarded are in the categories of what the professions call severely and profoundly retarded.

(10) Q. And the remainder are typically called moderately retarded?

A. Yeah, moderately retarded.

Q. And what proportion, if you know, of the mentally retarded are in institutions?

A. A little under 200,000 people are, I think, in public institutions right now.

Q. Are people of all retardation levels to be found in institutions would be defined moderately retarded?

MR. HOFFMAN: Objection.

Q. (By Mr. Ferleger) Would we find moderately retarded, mildly retarded people in institutions?

MR. HOFFMAN: Objection, the case focuses on Pennsylvania, and in addition, I don't they we've been given any foundation from Miss Glenn's information on that point.

Q. (By Mr. Ferleger) Answer the question, please?

A. Yes, there are mildly retarded people in all institutions.

Q. Including Pennsylvania, as far as you know?

A. As far as I know, yes.

Q. What is the procedure that professions use generally for identifying who the retarded are?

A. Well, unfortunately, they still—the main test is an IQ test that the professionals use to diagnose somebody as (11) retarded or to talk about what level of retardation they are. That, however, is not appropriate. The definition of mental retardation takes into account three different factors, IQ being only a factor that cannot be used alone. IQ has to be looked at in conjunction with the adaptive behavior of an individual as well as what stage in that person's life did he develop a problem in both the IQ and adaptive behavior. The standard definition used by the American Association on Mental Deficiency is a person would have to have substantial intellectual subnormally as well as impairments in adaptive behavior that originated in the developmental period. Person's live, in other words, it couldn't be an

adult that had a car accident at age 20. He wouldn't be considered mentally retarded because he may have become brain damaged. He would be considered a person that had been injured.

Q. Could you tell us, to help us learn some of these terms, what years that developmental period includes and what adaptive behavior means?

A. It is commonly considered the developmental period being birth to approximately age 16. Adaptive behavior is whether or not that person has learned to manipulate his own environment. Can he get along in society, does he (12) know how to care for himself and to socially be accepted in society by his behavior, has he adapted to the demands of his environment. It is very often that a person with a low IQ can get along in society. You do not have to have a high intellectual quotient as measured on standarized tests to be able to live in the community even by yourself, to navigate that community, to be able to hold a job and be self sufficient.

Q. Well, isn't there, as I think many people believe, some relationship between a person's IQ or level of retardation and whether or they not are found in an institution?

A. No, not at all. The people you find in institutions now, the reasons range from the parents don't want to let them come out or inappropriate reasons that they have been put in there.

Q. So we would find severely and profoundly retarded people living in the community as well as living in institutions?

A. You'd have the same people living in institutions living in the community, too, exact same people with the same needs and same impairments. It is circumstantial as to whether or not they have ended up in institutions.

Q. Regarding this process of identifying the retarded, you said IQ would be an insufficient indication by itself of (13A) the mental retardation. Could you describe whether and how mistakes are made in identifying whether someone is mentally retarded?

A. Well, there are many mistakes. The most common one historically has stemmed from the fact they have been associated with certain characteristics of individuals who are thought to have mental retardation. For example, at birth, it used to be if a child was born with a physical characteristic of a Down's syndrome child, mongoloidism, which can be noted at birth, the person has been assumed by many pediatricians and other professionals as automatically meaning mental retardation. That's been found not to be true. The fact that people have not had experience with individuals that have been allowed to live in the community that have Down's syndrome, that are allowed to have developmental programs and meet their needs, they hadn't seen that it is not necessary that Down's syndrome people are mentally retarded. They have to be given that opportunity.

Q. What other kinds of mistakes are made and how?

A. A lot of other handicapping conditions can cause the person to test on tests lower than their intellectual capability. Deafness is a good example. They have evaluated a lot of people on standardized tests and (13) thought they were severely mentally retarded and found out years later the problem was deafness.

Other problems are physical handicaps. Some people are born with multiple physical involvements that

don't allow them to have normal motor movement, normal speech patterns, normal capability to communicate and since they haven't been able to communicate or to walk like other kids or behave like other kids physically, they have been labeled as mentally retarded.

Q. If I recall correctly, as reasons for mistakes or errors in identification of the retarded, we have inappropriate use of IQ tests without consideration of other factors, which define mental retardation, physical problems such as deafness or other physical handicaps, assumptions that are made about somebody at birth or some early point—

A. Developmental speculations that are wrong.

Q. Have we generally covered that area?

A. Well, treating it that way makes it sound like IQ is a static indicator. That's a basic problem. A person may test low both on adaptive behavior and IQ and unfortunately is placed into an institution or some other non-developing-type atmosphere and he doesn't grow. But if he is placed in a facility that has (14) appropriate programs and typically kept in the community, then he grows every year. You can't say because he is diagnosed this year as mentally retarded, then he will be the same next year and the year after. That's a dynamic type of diagnosis.

MR. HOFFMAN: I'd like to interject for a second. I'd like to place a general objection on the record, that I think most of this testimony seems rather far afield from what I understood the Court asked the scope of this inquiry to be, which was that the mentally retarded and the mentally ill raise similar questions with respect to admission procedures to residential facilities.

MR. FERLEGER: That's right, the purpose of this obviously is to inform the court as to what mentally retarded are, who they are, where they are, in order for the court to determine whether or not there are differences, when that would require differential treatment.

Q. (By Mr. Ferleger) So people grow out of being mentally retarded in some cases?

A. Oh, in many cases, sure.

Q. And what many of us learned or absorbed as young people growing up, that someone who is mentally retarded has a (15) a mental age of a six-year old, is just going to be that way for their entire lives, is that a correct assumption or incorrect?

A. That's correct. In the past ten years in the field, we have learned that even people that have been diagnosed as serverely, profoundly mentally retarded, multiply handicapped in the past they have put them in institutions and haven't been given opportunities to grow. They laid in bed and looked at the white ceiling.

Q. I'm not sure if you misspoke or not, but it is not correct those people will remain the same?

A. If they are only given the opportunity to lay in bed and look at the white ceiling with no stimulation and no experiences, they will probably remain at that level of capability. But we have learned, giving them developmental opportunities in a normal, active environment, that many of the people are not mentally retarded, even those that we have thought were profoundly retarded.

MR. HOFFMAN: I'd like to make another objection to any of Miss Glenn's general comments, particularly on the quality of institutions and on institutions, on two grounds. First, that I think the

Court has ruled that the general conditions to be irrelevant and that Miss Glenn (16) is speaking generally, not in reference to Pennsylvania. That would seem to be irrelevant to this inquiry.

Q. (By Mr. Ferleger) Miss Glenn, so the record will be clear, if we come to any point at which your discussion on the mentally retarded somehow does not apply to mentally retarded people who happen to be in Pennsylvania, would could let us know?

A. Yes, I will.

Q. Thank you.

In terms of where the retarded are, could you tell us, if you know, what proportion of the retarded can be found in institutions and what proportion in community programs?

A. Nationally, only about 10 percent of the mentally retarded are in institutions. The remainder are in the communities.

Q. We have been using the term institution and community for awhile, I expect we will be for the rest of this deposition. Could you give us a working definition of those terms?

A. The statistic should clarify that I gave you, was talking about public operated institutions, so I don't want that to be confused with my definition of institutions. That's one type of institution, but the best definition of (17) institution that I've seen used and I use myself that an institution is any residential facility which is larger than a large family would be and exerts more controls over the individual than a large family would exert. The communities would be those—well, the larger environment surrounding those places that don't exert controls, that are normative, environments, either the person living in his own home or the person living in small residential facilities in foster homes and different types of specialized, but small, dispersed programs that are normative, normal houses, attending day programs away from their places of residence, being able to utilize community recreation, community social programs, where the life of the individual, the pattern of life and the rhythm of life is typical as it is for a person that is non-retarded. That would be the community definition.

Q. And those community facilities exist in, would you say all or most of the states in the United States?

A. There are community programs in every state in the United States, yes.

Q. And I take it from your earlier testimony you've seen at least some of these in Pennsylvania?

A. Quite a few in Pennsylvania, yes.

Q. With regard to institutions, could you describe for us, (18) please, the general nature of life in institutions and the dangers of life in those institutions, paying special attention to the adhered declaration of liberty that is involved in institutions?

MR. HOFFMAN: Objection relevant to the last qualifying phrase of Mr. Ferleger's question.

THE WITNESS: Well, institutions are inherently inwardly oriented and self-contained, which makes it even more difficult to return people to the community or have people learn normative ways of life because it takes away all the experiences from an individual that any other person would receive by either growing up in his own home or being provided a service in the same community or with other people that are in the community that are non-handicapped. What an institution does, unfortunate-

ly, is take each individual and instead of really looking at which areas of that person's life, there are really four spheres in anybody's life, and deciding which areas that person needs assistance in or training in or even some cases protection in, it automatically protects all four areas of the individual's life and over-protects in the sense of not letting him learn the normative experiences in other aspects. It shelters the home or residential area of a person's life, (19) the developmental area of a person's life, whether it be education or training or vocational types of opportunities, the whole learning experience, it goes on for a person to have recreation activities in the community, and other social activities, using banks, learning how to shop in the community, learning how to just navigate the types of recreational and social opportunities as other people.

The institution by sheltering all four areas, doesn't allow individualization. Some people may need assistance in their training program. They may not be able to work by themselves, now, in competitive employments; because that's true, that's no reason to shelter him in his residential area, in his recreational opportunities and experiences, or any other social type of opportunities. It is—the same thing goes for people that—some people do not even need assistance in living by themselves or living in a supervised setting, but he also may be able to work in a normative type of setting attending normal community activities and recreation and social, but an institution extracts, takes away liberties and opportunities in all areas once a person is placed there.

Q. Finish.

(20) A. There is really a whole lot and I have problems that institutions per se create. I could go through those. Some of the ones, the most important to anybody's growth, an institution automatically takes away by the fact of institutionalization. I could cover those.

Q. Please.

A. There are really two major growth dimensions or things that are important to anybody's growth, whether you are retarded or not. One of those things is model. Most young children and all the way up through your developmental period as well as in adulthood learn, not only from your program or what type of intensity of treatment you are given but you learn from peers. You learn by being associated with groups of other people in all types of experiences throughout your life. Unfortunately, what happens in an institution, is once a person has been committed to an institution or goes to an institution, all experiences by other peers that are non-handicapped are taken away. So you have a child in an institution that his only other models to learn from are other retarded kids or other handicapped kids. So what happens is the kid learns handicapped behavior instead of normal type of behavior. You can see this when you first send normal kids to regular pre-schools or first grade. They (21) all of a sudden start picking up behavior from other kids that the parents have never seen before. This happens in institutions, and you end up with a lot of maladapted behaviors, lots of stereotype behaviors, inappropriate social behavior, that he has picked up because he is around other people with similar problems or worse problems. You have common in-

stances where a child will have a certain problem, and maybe the place, like head banging or some other behavioral problem and the facility may be able to work on that particular problem; but because he associates only with other handicapped people, with similar other problems, he replaces that behavior with worse problems or with different problems but just as bad. He may lose his head banging but pick up biting or because of the depravation in the environment in institutions, a lot of individual stereotype behavior, you'll see kids rocking, you'll see kids spinning around or playing with their hands in front of their face all the time. That's institutional type of behavior so the modeling phenomena is most important.

To achieve this the programs both physically and socially for handicapped and mentally retarded kids have to be integrated into the community where the (22) opportunities for learning with peers and from peers is enhanced and not extracted from that person's environment. The social opportunities, the experiences, you cannot expect a child to learn to live in the community or to behave and respond as others learn to do as they grow up if you have extracted all those experiences from you.

Q. Go on.

A. It could be a long one, if you want a whole answer. The other largest reason for growth of anybody, not just retarded people, is the power of expectations on the individual and the power of an experience growth which is dictated by how many developmental challenges and opportunities the person is given. A person's growth is dictated by these challenges and the fact that he constantly has the opportunity to learn new things can be expected to do new things, he may fail some,

but that's a learning opportunity, too. What institutions have done is take away not only the developmental opportunities and experiences, but created an environment where the expectation level on the staff that work with a person is very, very low. They know he is handicapped. They know he is mentally retarded as soon as he enters the facility, so they (23) don't expect him to act normal, so all of a sudden he doesn't act normal. He acts different from normal people. That reinforces the fact that they knew that he was different so they continually treat him differently. Sort of a feedback loop of role expectation.

There are other problems with the facilities being too protective that cut down on developmental growth challenges for the person. The problems, when you have large numbers that you cannot individualize, every person learns differently, every person learns at a different rate, every person needs different types of emotional, social, as well as educational opportunities. When you treat people in masses, there is a tendency, and there is a lot of research to show this is common, to have a very dehumanizing environment by treating people, everyone alike, sort of like the fortification in the Armed Forces where everybody was treated, upon entrance into the Service, exactly alike same haircut, same clothes, the way they have to line up, then, that happens in the institution.

Q. So, for example, Irving Goffman's book, *The Silence,* would apply to mental retardation facilities as well as mental health facilities?

A. Definitely; in fact, it has a more overpowering effect (24) on a mentally retarded person because the person has not in some cases learned to fend off some

of the problems in the institution and the dehumanization features for himself whereas a person in a mental health facility or corrections facility may have learned that. It also has a much more powerful effect to institutionalize a mentally retarded person because it has been an indefinite placement and there is a long history of institutionalization by the majority of people there, get placed in an institution for 20, 30 years before they have the opportunity for something else. So you are talking about a powerful, long-term effect on the individual's life.

MR. HOFFMAN: Continuing objection to all the previous testimony and, I guess, what will come as being outside of the deposition requested by the court.

MR. FERLEGER: Don't object to what is to come. You haven't even heard it.

Q. (By Mr. Ferleger) Miss Glenn, could you describe whatever stigma or lingering discrimination and post-institutional life there is for the retarded person who is or has been in an institution?

MR. HOFFMAN: Objection, relevance.

(25) THE WITNESS: There is tremendous stigma for having been institutionalized. The image in a normal person's mind of a person who has been institutionalized is one of very aberrant behavior, of dangerousness. It is not one of somebody in need of just care or training, which some professionals think is the institutions' purpose. But the image is someone of a person that had to be put away to protect the community or to protect himself.

Some one—it is also—the very self image of the mentally retarded person is hurt by that. The fact of the stigma really hurts the person's later integration into the community.

Anybody who knows he was institutionalized fears his behavior, fears that something is going to happen to their children in the community or they are going to get robbed or some other problem just by the fact of institutionalization.

The discrimination that is placed on these people is quite traumatic.

Q. Hypothetically, if we had two retarded individuals, both of whom were at the same level of retardation and had the same physical handicaps and experiences, if one of them had been in an institution earlier in his or her life and the other one had not, could you (26) evaluate for us their chances of participation in community life, in work or in other areas?

MR. HOFFMAN: Objection, relevancy.

THE WITNESS: Certainly. One whole area, in answering that question, would be that within the institution the person would not have learned normal culturally appropriate and age appropriate dress, social behavior, how to relate to people, how to relate to the opposite sex, he would have problems in dealing with other people. He would stand out in a crowd. He might even talk louder because he has had to get used to screaming over the noise of others. He would be pointed out in a crowd and avoided because of the inappropriateness of his behavior, not allowed to participate in certain activities,

not allowed in many cases to be in competitive employment because of this type of behavior that he both learned in the institution and never learned to develop appropriate because he was in the institution, in the community.

The other would be more of a discrimination placed—the fear I was talking about, not wanting a person that used to be in an institution to be employed in a certain place because of fears of his behavior or certain acts of his would be either disruptive or stealing (27) or criminal or something.

Q. How realistic are those fears? Are the retarded generally a dangerous class of people?

A. Oh, no, that has been an old myth where people have not understood the difference between other types of people considered deviants, criminals, some people that are severely, emotionally disturbed, acting-up behavior. Mental retardation is a slow person.

Now, some of the behaviors that are learned within institutions sometimes are a problem, some of the stereotype behaviors that I mentioned, because of lack of activity, there is some aggressive behavior to get attention. There are some people with self-abusive behavior that's developed. But the fact of mental retardation only connotes a slowness in the learning process.

Q. Not a predisposition to dangerous behavior?

A. No, not at all.

Q. I hope we can get your assistance on qualifying something that I think is rather important. In your description for the last few moments of what institutionalization does to people and the effects on people, are you just talking about public institutions for the retarded or are you talking about institutions, the broader

(28) definition that you gave us earlier? In other words, the effects that you are talking about to be found in both public institutions and, let's say, the large private institutions where many families pay a lot of money to—

A. Definitely.

Q. Which way?

A. That the effect of institutionalization is the same whether public or private, if in an institution. There are varying effects mainly based on size. If you get down to a ten-bed institution, typically the research has shown that the powerful effects of the institution are not as great as a hundred-bed institution. But when you get larger than, you know, ten, 12, 15, 20, the same powerful effects of very large institutions apply to smaller institutions, too.

Q. So, for example, are you familiar with the Deveraud Foundation that runs some residential institutions?

A. I know them by—I haven't evaluated the programs, but I know of them, yes.

Q. From what you know of those facilities, would they fit into your general classification of institutions?

A. Yes.

Q. Would you tell us briefly, historically, how did these (29) institutions come to develop for the retarded?

MR. HOFFMAN: Objection, relevance, outside the scope of the deposition.

THE WITNESS: Why we have institutions, why institutions originally developed and why we have them today is very interesting because they developed only in response to an archaic perception of the mentally retarded. It used to be in society that the mentally retarded were perceived as non-

developing organisms, people that had no potential at all to develop. We have learned in the past 10, 20 years that this is not true. Persons that have mental retardation have just as much capability of developing as anybody else and on a continuous basis to develop, so that old reason for having institutions at all was knocked out years ago. Other perceptions were that mentally retarded persons, just because of mental retardation, were dangerous to society, were a menace, needed protection for their own sake, as well as to protect society. That perception also has been just torn apart and proven time and time again over the past 10, 20 years, not to be true. Thus, there really is no continuing reason for institutionalization because we have learned that mentally retarded people not only do not fit these old role (30) perceptions at all with our new learnings, and we found that the research shows that their development and growth capability is much enhanced if they are never institutionalized and certainly hurt when institutionalized.

Q. Perhaps you could just summarize in a sentence or two why it is that, as your testimony has indicated, it is your expert opinion that institutional care is not preferred and that community care for the retarded is the option that ought to be chosen?

MR. HOFFMAN: Objection, relevance?

THE WITNESS: The goal any social agency is going to have for an individual they take into their care is the training and habilitation of that person to allow him to take on as much independence as possible for that person, to learn to live in the community as independently as possible, even though, though some people will need some level of supervision, that goal cannot be achieved in institutions. You cannot learn to live and to manipulate in your environment by living in an institution. It is just totally the opposite. You don't learn how to use the normal things anybody else does, stores, banks, you don't learn how to cross the street. When you get out in the community, you may get injured trying to cross the street. You (31) cannot learn those basic goals that we would have for independence when you are totally segregated and apart from the rest of society.

Q. Could you list for us the reasons that despite this knowledge which has been in existence for many years on the nature of institutional care, why institutions seem to be hanging on in our society?

A. Oh, there are many, many reasons.

MR. HOFFMAN: Objection, relevance again.

THE WITNESS: They range from people, even professionals, being ill informed about the appropriateness of certain types of services and the effects of certain types of services on individuals. You still have some pediatricians who do not get training at all in mental retardation advising parents that their child should be institutionalized because they don't realize that we have come so far in this field, that the developmental potential and the expectations on a person can be so much greater than just needing custodial care. You have still the attitude of some people that people that are different in a whole variety of ways should still be put out of

sight, out of mind; so that society will not have to bother with people that are different, you have a system that has developed institutions (32) across this country that have developed a large power base. You have staff that work in institutions that have their own egos involved, that only they can do the right thing and that they are—well, in fact, they're perpetuating themselves because they feel they are doing the right thing, they, too, being ill informed. Typically a lot of old guards that still hang on to the old beliefs about segregating the handicapped, you have power bases having been developed through the history of institutions and bureaucracies by unions and civil services and others that the main purpose is to protect the jobs. So we have not been able to faze out many institutions because of these types of external demands. The fact that institutions have been in some states, almost all states, in the past and in some states still today, the major state funded program, you have a situation where they look more secure where parents can trust that the state will fund that institution every year, thus they want that security for their son or daughter, even if they admit it is not the most appropriate placement. They don't know if they had the person live in the community in some other type of program or by himself that the state will take care of him if they die. So it looks like a (33) more secure thing because you can see the big monument on the hill with the smokestack and water tower and you know it will always be there. So it has been a security thing for some people.

Q. Could you tell us please what variables are involved in—where it is that a retarded person receives care or habilitation? Is it the level of retardation? Are there other factors involved? And if so, what are they?

A. Well, there are many reasons why a person needs service. On the one hand—

Q. Maybe I should bring that up. First, is it the level of retardation?

A. Not at all, no.

Q. Aren't there some people who are so retarded that by the very nature of their retardation that they ought to be in an institution out of the question?

A. No, none. There are three global areas of why a person would need any type of out of home type of placement, to be out of his own home, and there are a lot of sub reasons within each.

Q. Why don't we cover them one at a time.

A. Okay. Let me list the three, then I'll go into it.

These three reasons are typically a problem in the family, the family, for any number of reasons. And I (34) enumerate those, as having a problem. They cannot keep the child in the home, or there is a death in the family. There is too many other kids in the family and since this one has a label, the retarded kid has a label. There's the kid that has a place to go, there is no family, some are abandoned kids, kids that belong to social service agencies like Welfare because they have been removed from the home because of abuse. So a problem in the family that has nothing to do whatsoever with the child's clinical or educational needs is one whole category.

The second category would be a problem with the individual, mentally retarded person himself. This is the

most minor area. A problem like that may be something like the child has developed extreme behavior problems or is extremely hyperactive and maybe sleeps only two hours a night and bounces off the walls the rest of the time. That builds up such a stress in the family, inability to keep that child in the home without assistance, and when there are no resources to give that family assistance, then that person may need out of home type of service.

The third major area are things in the community. The community or, let's say, the surrounding neighborhood (35) of a person that's mentally retarded living at home, may not like certain of the differentnesses of that person, which may be just his looks, it may be some social behavior. A lot of pressure from a community causes a family to have to make a decision, either move from that community or have the child live somewhere else because of pressure from that community.

Q. Considering these factors that you're mentioned, the communities, individual, the family, and dynamics among those factors, do factual conflicts or disputes arise, and if so, could you give us some examples?

A. Quite a few factual, in several broad categories, conflicts come about all the time. A lot of these are between the individual or the family and the community. For example, there are a lot of cases where a community will pressure a family or social agency to institutionalize, say a young adult retarded person because they say he is creating problems in the community. When you really take a look at the situation, you typically find that what has happened is the individual can have lesser capability than some of his peers of that age, let's say, a 25-year old man. He will still be in the developmental stages of someone that may be is 13, 14 years old or ten or 12,

and he may have enjoyed doing those types of activities and (36) maybe doing it with other ten-or 12-year old neighbors in the community. The community gets very upset, that they think this young man, all he wants to do is play, is molesting their sons and daughters that are younger than him in the community.

Q. That may be a perception—

A. It is an inappropriate perception.

Q. Appropriate or—by inappropriate, you mean in error?

A. Yes, in error, definitely. Those things don't come out, though. Just the pressure builds up on the family from a lot of different directions and they think it is best for everybody to have the person institutionalized.

Q. Since we're focusing on juveniles, that could also be true of people 18 and under?

A. Certainly.

Q. Those kinds of factual—

A. Certainly. Parents of normal kids that have not had exposure to mentally retarded people really get upset when somebody different is—even of peer age—is playing with their children in the community or if they are acting a slight bit different. They don't want their children associating with that person. Typically, there is no real problem at all. It is an understanding of the range of differentness.

(37) Q. would it be correct to say that factual disputes can arise in all the various contexts you described regarding the communities, the individual, the family factors, for institutionalization?

A. Oh, certainly. Definitely. There are a lot of —it is hardly ever a problem in the individual or with

the individual that creates the situation for institutionalization. I mean, it is a whole range of things involving stress on the family for any number of reasons in many instances that doesn't even involve the retarded person, the stigma on the family because of historic problems of acceptance of differentness by other people. You have a value conflict there of the parents being ashamed that they have a retarded person in the family versus the retarded person or having any needs.

Sometimes families can't afford the care of a person that has minor, more special needs than the normal kids in the family, or there are no resources to help that mother learn to deal with the social agency that they have to deal with to get other services for the retarded person. The level of expectation, the doctors that first diagnosed the kid, told the parents that he would never grow. It is a low level of expectation out of ignorance on professionals' part.

(38) Sometimes where a person lives, there are no services so they feel they have to send their son to the next largest town a hundred miles away to receive services.

Q. Well, coming from what you are describing, I'd like to ask you, Miss Glenn, whether you have an opinion on whether or not parents should be depended upon to make the decision on whether or not their child should be in a mental institution?

So the record will be clear, when I say child, when we speak about juveniles, we are speaking of people 18 and under.

MR. FERLEGER: Off the record.

(An off-the-record discussion was held.)

(A brief recess was taken at this point.)

Q. (By Mr. Ferleger) And also of people who are retarded?

A. Okay.

(The last question was read back.)

THE WITNESS: From my experience and from—the literature is quite extensive on problems parents have when they have a mentally retarded child. I certainly would say parents should be involved in the process of decision making but certainly not the person that makes the decision.

(39) The literature, most of it, really talks about when a person, a family, a parent learns that they have a retarded child, either at birth or at any time during that child's life, they learn the person is retarded. And then what they have to deal with in the sense of their own emotional state as well as the stress in caring for somebody that needs extra attention, as well as the stigma that goes along with society's acceptance of retarded people, that they emotionally should not be the ones to make a decision. They go through various stages of what professionals call novelty shock, where they have expected a child to be normal, who they planned to go to college, planned on him being a doctor or maybe a lawyer, and all of a sudden, their expectations are shattered about what their child is going to be able to do. And there is a greater emotional stress which often results in them not wanting to deal with it, and not having any support to deal with it, so that rejection of the child starts and inappropriate and certainly unneeded institutionalization results from that.

The value conflict is another one. There is a lot of literature on where because society doesn't accept a person, the family really does not want to deal with them being a different family in the community, and (40) rejecting the child for that reason.

These first two, however, are things that, with support in the communities, parents get over. But unfortunately, the typical response to these—get over very quickly—but the typical response has been to not deal with that and institutionalize the child.

Then there are problems with reality stress situations of value to deal with the child that is different. But even aside from those emotional difficulties that parents are constantly going through with pressures from other people in the community, pressures from relatives, you know, not to say they have a retarded person in the family, not having the —being able to have the same type of expectations on the child and inappropriate idea often called by professionals that the child will never grow or never be able to talk or never walk.

Q. It is your testimony that you have heard of actual cases in literature, documents, cases where pressures like you mentioned from family members, not to admit that there is a child in the family retarded, have resulted in institutionalization?

A. Certainly.

Q. And where the novelty shock, the value conflict, the (41) reality stress as you have described, those have resulted in institutionalization?

A. That's been one of the main reasons for institutions. There are others, more concrete types of reasons

that, again, hardly any of them relate to the needs of the individual child. Conflicts between parents, conflicts because of the guilt of what is appropriate for the person or conflicts in their capability to cope—any child is hard to raise for a family and for a family that hasn't raised children and there is a lot of projection to a handicapped child that he is creating the stress problems in the children. If they are created by other reasons, other problems, financial problems in the family, it is often projected on to a handicapped person. It is a stress laden time for parents to try to insure they are receiving the right services and they are often at the end of their rope and think that maybe if the child is out of the home in what are typically named schools for the mentally retarded, they think maybe they will get the education there.

I have a retarded brother and my parents thought at one time because they could not get a good educational program in one community that because the institution in that state's name was blank school for the (42) mentally retarded, if they sent my brother there, he would get an education. It was out of ignorance. They considered it, which they didn't do, but—

Q. To what extent does the ignorance of alternatives, including community care, make parents less reliable to be the decision makers on the institutionalization of their children?

A. I was going to talk about that. Because of the wide range of community services that have developed over the past few years for the mentally retarded, even in Pennsylvania, there is a very wide range of community services. But they are relatively new in the past six or seven years—most people only know of the services of institutions, because they have had hundreds of years of

existence. They are the ones that are the most visible physically in the communities because they are large—not in the communities, in the country usually, large facilities. They have been run by the state and if they approach a state for services, that's often the only one they know about, the professionals they go to often don't know of the range of alternatives and recommend institutionalization, unless the—

Let me back up. Most parents don't have even the knowledge of the right professional to go to. Most (43) parents find out from their families that the child is retarded or find out from a school psychologist, once the child enters school. And they have not noted any developmental lags in childhood. Those two professionals, or almost any professionals, unless associated with the service agencies that provide the range of alternatives, only know of institutionalization.

The pediatrician may not have had any even education in the medical school year. That's just starting as a part of a physician's training. He's just learning about mental retardation. That doesn't even include alternatives to institutionalization, so the recommendation to the parents from those most trusted, like a family physician, is often a choice based by someone that is ignorant to the alternatives to that.

Q. Can't parents, when they are speaking with—they are reporting to doctors, psychologist, and other service agencies, about their retarded child, can the parents objectively report the behavior of their child or the condition of their child when the issue is institutionalization?

MR. HOFFMAN: Objection, outside the scope of this deposition.

THE WITNESS: Not always. And the reason for that (44) is more of a—a family is not going to, in the vast majority of cases, even have the thought of institutionalizing their child until they have reached a point of high stress of either not being able to get other services or stress in the family conditions, in the home, that have them seek institutionalization. At that point in time, it is high crisis time for a family, high guilt time, where there is much guilt in the decision making process. And a lot of that gets projected on to their descriptions of the child's behavior or the problems that they have had and they think they won't get any service unless they really exaggerate that this person is a tremendous monster or they won't be able to carry through with the decision that they finally made to seek institutionalization.

So there's a definite problem for that reason. The other problem is that parents typically do not have automatically certain behavioral intervention types of schools, and a parent may have thought they have tried everything to work with the child with a specific problem, but with just a little advice and consultation from somebody with behavioral intervention type of techniques, that that problem could have been resolved of or diminished. So that the alternatives to the parent (45) ever needing to apply for institutionalization have not been exhausted in most cases.

Q. Another alternative for the gate keeper, decision maker function, regarding the institutionalization of retarded juveniles, would be the institutional staff or pos-

sibly various community mental retardation agencies or other referral agencies. You may want to separate those two, but could you tell us your opinion as to whether those institutions and/or community referral agencies should be relied upon to make the decision?

MR. HOFFMAN: Objection, again, outside the scope of this deposition.

I'm just making my continuing objection. The whole issue in this case is who decides. If we can't get an opinion from this expert on why we can't trust parents to decide or why we can't trust institutions to decide or community agencies, then we probably should have been dismissed back when you filed your motion to dismiss a few years ago.

I understood the issue that you could have raised all of this testimony before the Court prior to our hearing on March 31st, but chose not to and instead, I understood that the Court has asked for or permitted an additional deposition solely on the issue of whether the (46) same considerations apply to the mentally retarded as to the mentally ill. I think that should be the scope of this deposition, as I have indicated in objections. I think we have gone far afield from that scope.

MR. FERLEGER: Not at all. The same considerations that were discussed by four of my experts and four of your experts in the initial proceeding are the very considerations that I'm asking Miss Glenn to give us her opinion on as they apply to the mentally retarded. We already have opinions from experts on how they apply to the mentally ill. We're

now getting an opinion on how they apply to the retarded.

Q. (By Mr. Ferleger) Could you answer the question, please?

A. First, there is a basic conflict of interest for somebody in the institution to make a decision about whether or not a person ought to go to that institution. That would be sort of like a store owner deciding whether or not a customer ought to come into his store or somebody else's store. Institutions, as I indicated earlier, are sort of fighting to prove their necessity and justify their existence. All the research in the past 35 years has shown that institutions are not appropriate for the developmental growth of mentally retarded persons, but there are a lot of people that continue to try to justify (47) their existence and the only way they can do that is by having a population. With the move Federally and by states and professions that recognize the inadequacy of this historic institutionalization having a dramatic move toward deinstitutionalization, there is a real conflict where institutions have to have people to prove they should still be around.

Another reason is the institutions, in the vast majority of cases, if not all the cases, would be ignorant of the other alternatives to someone being placed in their institution. Their responsibilities, obviously, would be the operation of that particular program.

Also, the staffs of institutions by the very fact that they work there, think that they are doing the right thing, think that they are the best place for people, and so everybody gets ego involved in what they are doing and have been doing for years and think only they can do the right job.

Thus, an institution staff making a decision would naturally have a tendency toward saying people belong right there in their institutions.

There is also the issue of institutional staff having a mentality of over-protectiveness, really feeling (48) a person has to be brought into the institution and serviced by their staff and protected in that type of environment or the staffs wouldn't necessarily work there.

Q. Would it be your testimony that these phenomena would occur regardless of the goodwill or good faith of the institutional staff?

A. Yes, definitely.

Q. So the influence of the conflict of interest, the ignorance of alternatives, the ego involvement, in your experience, would affect and has affected decisions on admission of particular children to institutions for the retarded?

A. Definitely, even here in my own state, where our policy is to get everybody out of institutions and where I've attempted to hire superintendents that have the same ideology, but it is very hard to find people that want to be superintendents of institutions now because they know it is a dead end street and you cannot get necessarily highly qualified people. I have succeeded in getting these people, but, a change over time, where our policy is to get people out and superintendents start sneaking people in, to make sure they can get the same amount of money next year, same census on the (49) roles, it is a justification of your existence, I guess, type of behavior.

Q. You answered my question with regard to the institutional sphere.

Now, can you tell us your opinion as to whether or not the recommendations of community mental retardation agencies or other social agencies or the reports of a doctor or psychologist ought to be accepted as a decision to institutionalize a juvenile?

A. I think I covered the doctor, psychologist issue a little bit before.

Typically, number one, mental retardation is not a medical problem and physicians are not trained in either mental retardation as a rule or service delivery. They are interested in medical aspects or the symptomology or the syndromes that are associated with the mentally retarded, so the service delivery needs of a person, are not their bailiwick. Psychologists—well, there is a whole range of professionals that do work with community programs and different types of social agencies. I'll talk about social agencies, psychologists to social workers to educators, they, again, don't know all the alternatives, (50) have only had experience as an individual professional with certain types of services, maybe associated with certain types and have their own ego investment in those types of services.

The major reasons, you could not rely on those social service agencies is more one of the pressures on those agencies and the fact that those agencies, the large case loads in almost all cases, the attempt is to find as rapid a placement as you can so you don't have to deal with that person on a 24-hour basis because of the problem, try to find somebody else to be responsible for that person in a quick way, administratively. They use institutional placement as a cop-out for the sometimes difficult job of getting through the red tape of getting an alter-

native placement or developing an alternative payment. Many social agencies are resource-bound in the sense of what they are able to pay for and often institutions are free because they are publicly operated.

Q. They may recommend an institution even though they may be aware that some other alternative would be more appropriate?

A. That often happens. Because either the only thing available, the only thing they know about or they don't have (51) time to deal with the individual aspects of the person's needs such as to match together a lot of resources to make sure it is individually appropriate for the person.

Q. Dr. Michael Ingall testified earlier in this case for the mentally ill children that over-crowded clinics may over-recommend institutionalization. I take it from what you said that that happens in the retardation area as well?

A. Oh, very often, yes. There is often, also, some of our universities are still not putting out professionals that have the appropriate ideology about the more severely and profoundly retarded; most of the universities are still training special education teachers to work only with kids that are moderately, mildly retarded, can sit nicely in their classrooms of ten or 12, don't have more severe problems. So even though they can classify them as a professional in the field of mental retardation, they have not had the experience to see the dramatic effect of growth of a person if he is left in a community. So their recommendation, out of ignorance, would be an institution.

Q. Miss Glenn, I know that since I first contacted you about this deposition, only four or five days ago, you

(52) may not have had time to go over very much material on this case, so I don't know what your answer to this question would be, but have you had an opportunity to read the opinion of the District Court of July, 1975?

A. I have to look at it to see if I've seen it.

Q. I show you a copy of the opinion. See marks on it. But my first question was whether you read the entire opinion or not?

A. Not the entire opinion.

Q. Do you have an opinion, Miss Glenn, on the question of whether or not juvenile mentally retarded persons should be provided a hearing with regard to their institutionalization and whether, at such a hearing, they ought to have the right to notice to counsel, the opportunity to cross-examine witnesses and present evidence, to be present at the hearing?

A. I certainly have an opinion on that, yes.

Q. Can you tell us your opinion, please?

A. When you're dealing with any placement decision, for example, for a mentally retarded person, you are dealing with a life decision for that person. I mean, you're not dealing with like a—typically, in a mental health case, it might be a temporary admission or in a criminal case, it is at least a time limited type of decision. (53) You're traditionally and typically dealing with something that is going to affect that person's life for the rest of his life, even if he doesn't stay in that institution the rest of his life. That is a heavy decision, I mean, that is a decision that the power of it is tremendous. That's one reason it should not be left to the parents solely.

There has got to be some considerations taken into account. There has got to be an adversary type of pro-

ceeding so all sides can be heard. It's got to be totally impartial. I would even say it could be an administrative —couldn't be an administrative hearing. There are too many conflicts of interest to that and there is not enough real prestige to that to bring up all the peers and the type of image that would make people take it as a serious consideration. You are not dealing with something like a hearing that is going to affect one aspect of a person's life, like a Welfare financial assistance hearing, or an appeal or something like that. That only affects a minor thing in an individual's life. This decision on placement of a person is going to affect him for the rest of his life, so there would have to be a hearing, and in my opinion, a judicial hearing because of the image and their proven (54) impartiality and that can really find out the facts, can insure that that person has a service provided to him that matches up with his individual needs with the setting that can both provide those needs in accordance with plans for that person, most appropriately, in the least restrictive setting. It takes away the least number of rights and avoids him of the conflict that would arise.

(55) Q. Did you see any way in which a hearing could harm the retarded juvenile involved—strike that.

Can you see any way in which a hearing could harm the person who is alleged to be mentally retarded and in need of institutionalization?

A. No.

Q. Some people have indicated that the process of participation in a hearing could be very traumatic, perhaps excessively traumatic, for the person.

Have you any opinion on that question?

A. I think I'd see it the opposite. Just the dignity given to a person and the self-worth gained by the fact

that a large number of people would be interested in him getting the appropriate service, the right to be represented by somebody that is going to take his interest first and foremost, even if those interests conflict with the parents' interests, I see more of a dramatic positive side to the person in that hearing.

Q. I want to make sure I heard three of your words correctly.

You said self-worth gained, g-a-i-n-e-d?

A. Yes.

Q. Would a hearing be, in your opinion, either an undue interference with a private family matter or (56) would it contribute to some possible breakdown of the family?

MR. HOFFMAN: Objection. I'm not sure I think that's within the areas in which Miss Glenn has been qualified as an expert.

Q. Understanding, of course, we are only talking about mentally retarded people?

A. Yes, I see it as exactly the opposite. When a family goes through the problems of decision making that I mentioned before, there is much trauma of deciding whether or not to have the child removed from your home to go anywhere, guilt feelings of the parents, like he is shirking his responsibility and not really knowing whether or not his decision is right or not, and that feeling of never knowing if you made the right decision lingers on with parents for years and years and years and can create its own problems of internal family trauma.

In fact, it hinders even future family involvement with that child because every time they see the child when

they go visit him in the institution or wherever he is, it surges up all the old guilt feelings and indecisiveness about whether or not they made the right decision.

(57) A hearing, on the other hand, would answer that for the parents, you know, would make sure the parents felt comfortable with the decision, the fact that other people were involved in that decision, it was heard on both sides, they brought in other testimony, that there was finding of fact.

Also it would cut down on the trauma in the family if there was internal, which there often is, conflict in the decision making.

Let's say—well, in many cases, the father will say let's institutionalize the child, the mother will say no, the father will win, and it will create problems in the family for the next 50 years. So an impartial hearing with fact finding and decision making can decrease the trauma, not increase the trauma.

Q. Could you list for us what benefits a hearing would have for the retarded juvenile and his or her family?

A. I think I just listed a few.

Q. Well, could you list them again?

A. Well, you've relieved the parents of the sole decision making of their own without assistance that may create the problems I mentioned. You relieve the institution of the burdens of those decisions, too. You (58) do have the fact finding, if there is the conflict we talked about earlier, and the reason for someone coming to the hearing for a commitment procedure, you have a forum to find out what other alternatives there are, you have a forum for actually finding out what the reason is for

the problem or for the potential commitment so that maybe other resources can be applied to that, and you can determine what the individual really needs.

It would, again, enhance the self image of the person, and I guess you could—to me, one of the most important things would be if they are really considering institutionalization for the first time, there would be a place where the institution would have to prove that it could meet the needs of those individuals. That's what has never happened in the past. People have assumed, because it's an institution for the mentally retarded, that it can meet a wide range of needs. But the institutions never had to prove that for one person, John Jones, who needs 12 different needs, that that institution could meet those needs.

So it puts a burden back on whether or not the actual service needs and objectives that (59) need to be met for that individual can be met by wherever he is committed to.

Q. You don't see any other alternative for securing those benefits besides the hearing we have talked about?

A. Not where it would be impartial and not subject to administrative convenience types of decisions that social service agencies have to make, no.

Q. Now, I'd like to turn, in our final moments, to the regulations that were enacted in 1973 by the Pennsylvania Department of Public Welfare regarding the admission of juveniles under the 1966 Mental Health and Mental Retardation Act, Sections 402 and 403 of that act.

According to stipulation between the parties, these regulations are now used and applied only to the mentally retarded, not to the mentally ill.

For convenience, I would like to explain for the record that I am referring to the regulations as they are reprinted in Footnote 5 of the initial opinion of the District Court of July 24, 1975, as printed at 402 Fed. Supplement 1039, Footnote 5 on Pages 1042 and 1043.

Do you have those regulations in front of (60) you, Miss Glenn?

A. Yes, I do.

Q. Paragraph 1 provides that, "All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist."

Could you tell us, Miss Glenn, whether you note any deficiencies in that paragraph?

To save time, you could incorporate by reference some of your earlier testimony; but I'd appreciate your just telling us what you find, what deficiencies you find, in this provision?

A. I think I've covered the fact that individual pediatricians or physicians or psychologists or even groups thereof do not, historically, have the knowledge appropriate to make decisions like that, do not know the alternative for services available in the communities, and a provision like this is certainly subject to abuse.

One of the patterns of behavior for parents attempting to institutionalize their child has always (61) been a shopping behavior, to shop around until they could get the right words on the right page from whatever physician they could find or psychologist; not just parents, other

social agencies, social case workers, welfare workers. That's subject to abuse too readily.

Q. I take it your earlier comments on the problems depending on institutions and community facilities would also apply to this paragraph?

A. Yes.

Q. Paragraph 2 of these regulations states, "This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care. However, a medical or psychological evaluation may accompany a referral of a mentally retarded juvenile."

Could you comment on that provision, please?

A. Well, obviously, the reports by any of what we talked about in provision 1 of the individual pediatrician, psychologist, psychiatrist, are subject to the same errors of those individuals. That's certainly a limited documentation to make a life-long decision for a person, what a psychologist or a (62) psychiatrist says.

Q. Does this Paragraph 2 describe the required evaluation in a way which would assure it would contain the information necessary to decide whether a child needs institutionalization?

A. Not at all.

Q. Generally, what additional information would need to be required in order to consider those questions? What is lacking here?

A. Well, two major areas. One would be the specificity of the type of information on the person that would be required, of his needs, and what types of environments as well as training programs would be most appropriate to meet those needs, so certainly a specification of the type of clinical information on the individual.

On the other hand, information relative to whether or not the person could be kept in the home if another range of services were provided or how decisions are made about service delivery to meet those objectives for the individual in what the alternatives are to total institutionalization of a person.

Q. Paragraph 3 of the regulations states, "The Director (63) of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile."

Could you comment on whether this review by the institution of the proposed juvenile involves any deficiencies, in your opinion?

A. Well, I've already covered that I don't think the institution should make decisions; but certainly for a regulation covering commitment, any person that is involved in that decision should not be an after the fact type decision, which it sounds like this is. It sounds like a person would have to have been placed into that institution before that particular level of review has taken place or could even take place.

Q. I take it you are referring especially to the last four words, "shall discharge the juvenile."

A. Yes, that's what made me believe—

Q. Postadmission?

A. It would have to be postadmission, yes.

Q. Paragraph 4 of the regulations requires that the telephone number and address of the juvenile's parents (64) person who is requesting admission for the juvenile must accompany the referral. I don't think I have any question of you on that paragraph.

Perhaps Mr. Hoffman will. It seems to me the general requirement under the statute that the person who is seeking to admit the child disclose his or her identity.

Paragraph 5 of the regulation states, "Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission, and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached)."

For mentally retarded juveniles, could you explain any deficiencies you see in this paragraph?

A. This paragraph, on reading it, I would assume it was written for emotionally disturbed, rather than mentally retarded. Mentally retarded people (65) would not be able to read the written notification or understand the explanation of his rights or have ever had an opportunity to learn how to use the telephone or understand what counsel is, so it's inappropriate for this alone to be the type of notification or capability of the individual to receive counsel on his own understanding of that, being able to do that.

Q. For that minority of the retarded who might know how to use the telephone or might know what counsel is, could you describe whether or not that juvenile would be able to independently and freely exercise the choice that would be involved in stating an objection to the institution and calling or notifying counsel of the client's feelings?

A. Certainly some mentally retarded people would be able to. However, mentally retarded people that are in institutions are typically afraid to.

There is a certain atmosphere of pressure that goes along from staff and peers not to complain, not to go outside the standard rules of daily routine of the institution. I can see them being reluctant, even those that could do it, to actually carry through with these procedures.

(66) Q. So if a retarded person who was in this minority who was more articulate than most didn't object to being there, could I assume that that person was satisfied with the institutionalization?

A. Not at all, no.

Q. Paragraph 6 of the regulations is rather lengthy. I won't read the entire paragraph into the record.

It generally requires that, in the event a juvenile does object, the juvenile being 13 or older, to remaining in the institution, that the Director may continue the institutionalization for two days, during which time he notifies the applicant for the commitment and the referral unit so that either may institute a court commitment proceeding.

The Director of the facility also notifies potential legal services; and if a court commitment proceeding is begun, the juvenile remains institutionalized. I'd like you to first state whether or not you have read the entire text of the paragraph, since I haven't read it?

A. Yes, I have.

Q. Could you tell us any problems that you see with that paragraph, again incorporating any of your earlier testimony by reference?

(67) A. Well, the basic problem is it puts the burden on the retarded juvenile to initiate the process. Some

retarded persons are not going to understand it to initiate it.

Others, as I indicated, because of the social pressures within the institution, are going to be reluctant to initiate a process like that. It's putting an awful lot of burden on young retarded persons to stand up against a big institution, which is not a common behavior.

Q. I note that Paragraph 8 of the regulations says that if the patient is "incapable of understanding the notification, it shall be written on the notification."

Do you see anything in the regulations that would provide any substitute advocate for the person who doesn't understand the notification?

A. No, I don't.

Q. Does that present any problems for you in evaluating these regulations?

A. Especially when you're dealing with mentally retarded persons.

Q. Could you tell us what other general deficiencies you find with regard to these regulations, regarding (68) either the time of the hearing, the age restrictions involved, any other kinds of problems?

If you like, I can be more specific in my question; but if you can answer, I'd appreciate it.

A. One would be the one that the Court noted here, that there is no time, there is no time procedure set up where he can assure there is speedy decision making.

The other main deficiencies deal with the fact that there is no specificity with respect to the objectives set for the individuals, time frames on the objectives to be met by the institutions if the person is placed there. You still have an indefinite commitment here. If a person has only one problem—the person may have only had one

problem that caused the initiation of commitment procedures that could be corrected in one week, two weeks, or three weeks or some other time frame. But there is no responsibility within the regulations to enumerate the objectives for the individual, enumerate the time frames that the institution is to meet these objectives, such that there is review and the person has an opportunity to get out of the institution after the objectives are met that caused the commitment proceeding in the (69) first place.

Q. Giving the State of Pennsylvania the benefit of the doubt and assuming that a hearing would be held within a few weeks to a month of institutionalization or even, say, a week or a couple of days, are there harms that would likely result to either the mentally retarded juvenile or someone who is mistakenly thought to be mentally retarded from that short period of institutonalization before all these procedures can be given effect?

You may have answered that earlier.

A. I'm not sure I understand the question.

Q. Let me clarify it a little bit.

You described earlier in great detail the harms that can be caused by institutionalization. Assuming that the State of Pennsylvania does a better job than is called for in the regulations, or even assuming the regulations are followed, so within a few days or week or month a hearing is held—

A. After the person is institutionalized?

Q. After the person is institutionalized, are there harms during that interim period prior to the hearing that can befall an individual?

(70) A. Twofold, yes. Assuming, on my part, that the Pennsylvania institutional services that people would be committed to are typical of the rest of the United States, where they are understaffed, overcrowded, professionally isolated in most instances, the real problems of institutional abuse that goes on—there is a potential for even physical harm to the individual on a short-term basis, crowded wards, lack of staff, clients to have a tendency to harm themselves or each other because of lack of supervision and lack of other things to do besides stereotype behaviors or fighting in the institution—staff abuse is pretty common, too, in a contained environment, low paid individuals that are overworked, that have so much responsibility and so many children to watch, that they get frustrated, and there is abuse that goes on in the institution that is harder to monitor in an institution.

So, to the individual himself, there is certainly physical harm that could happen.

The other harm really is back to the emotional decision making process of the parents. Once that commitment has been made, I mean, it's like closing the door on the type of parental-child relationship (71) that existed in the past. There is much more resistance, even if a lot of alternatives are offered to the parents, either in the home or some other residential setting; to go through that emotional thing again, to then go through it to place the child somewhere else or to have the child come back home, even with the amount of services that would have initially prevented them from ever having to institutionalize the child.

So for a second step to be taken for this person for his hearing after he is in the institution is going to be a lot harder for the parents to accept.

Q. I would like your answer and your opinion on an issue that has frequently come up in my discussions with other people regarding this case.

You have said that you would support a hearing and counsel and procedural protections for the child proposed for commitment to an institution for the retarded.

Suppose a family seeks such a hearing, a hearing is held, the family explains their reasons for wanting the child to be institutionalized, the (72) stress and crisis of the family is all laid before the impartial tribunal deciding the question, and the decision is, because of either the alternatives available or the facts of the particular case, that the child should not go to the institution, but should remain uncommitted, should not be placed in the institution.

Wouldn't it be worse for the child to have to return to this family that has just asked a tribunal to commit the child?

Do you have any thoughts on that?

A. I don't know what you mean by worse for the family, I have not—

Q. A lot of people seem to feel that the decision—maybe I'm asking you whether you feel this way—the decision at the commitment hearing is simply do we commit the child or not; and then, if the decision is not, then the child goes back to the same distressing situation, possibly the home that the child came from.

A. Well, through the hearing process itself, a lot of things are going to be cleared up that may have been—well, the fact finding, the conflict that may arise, those would be cleared up, so many (73) of the problems may have been resolved.

The exploration of alternatives would give the parents, as well as any social agency involved, other resources to apply to that family with that child or for that

child out of the family that would not have been exhausted if the child had been institutionalized.

So, yes, there may be an impact. But I think it would be a lot less injurious to the person than to have that person institutionalized because they would have knowledge now of the facts and any other resources and social agencies to get appropriate services for the person.

Q. And you just said "they."

Do you mean the family as well as the retarded individual?

A. Yes.

Q. Here in Massachusetts, for your state facilities, do parents or guardians apply for, and do the institutions accept admissions of mentally retarded juveniles?

A. Because of the problems inherent in institutions as not being appropriate for people, we have closed admissions to institutions in Massachusetts.

Q. So what we have been talking about from the point of (74) the Pennsylvania case doesn't happen here in Massachusetts?

A. It is very rare that we cannot develop an alternative for a person or provide services in a home; and in those rare instances, like the whole family dies except for the kid and he has no place to sleep for that night, there is a time problem as well as a service problem, an admission could be made, but only short term until, you know, a program is developed.

Q. How long, typically, would that short-term emergency—

A. It varies so greatly. We would definitely try to keep it under 30 days. But that is rare.

Q. How long have admissions been closed to Massachuetts institutions?

A. Approximately two years.

Q. And—

A. Before I got here, they closed admissions to children, and I don't know what year. I don't know the age —I think it was six and below, young children.

After I got here, we closed it to everybody.

Q. And I take it that you have not had any catastrophe or crisis arise in the care of mentally retarded juveniles in Massachusetts by the unavailability (75) of those institutions?

A. No.

MR. FERLEGER: I have no further questions. Thank you very much.

Mr. Hoffman may have one or two.

THE WITNESS: Can I make a phone call?

(Recess.)

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(76) *Cross-Examination*

BY MR. HOFFMAN:

Q. Could you describe for us your experience in evaluating facilities in Pennsylvania?

A. Yes. I was put on contract by the Department of Welfare in Pennsylvania in, I believe, 1972 to run three training programs for staff and citizens and program providers in Pennsylvania to learn to use the program—to use the PASS system, Program Analysis of Service Systems. That is an evaluation system.

Each of the three workshops I held, one in Harrisburg, one in Pittsburgh, one in Philadelphia, between '72 and '73, I believe—it may have been part of '74—the

workshop is held where one or two days is more ideology and theory and how to use the instrument, and the last two or three days is always evaluating a whole range of different services so they learn how to utilize the evaluation instrument itself.

So I not only participated on the teams that evaluated services at those three workshops, but supervised the evaluation of all of the review teams that were being trained. There may have been (77) at any one time five or six different teams that were going out to evaluate two to four different services in those areas. So I supervised and participated in the evaluation of approximately 15 or 16 different services in and around the areas. Well, we spread out quite a bit around the areas, but around Harrisburg, Philadelphia, and Pittsburgh.

Last year I was asked by the Justice Department to evaluate some of the community programs in the three-county area that served Pennhurst, or Pennhurst serviced people from those three counties. So we evaluated a range of community programs, but some day programs, in that area.

MR. FERLEGER: Excuse me. For clarification, could you tell us which Justice Department, whether it was five counties or three counties—I'm not sure whether you were saying it was three counties you were in or whether the lawsuit involved—

THE WITNESS: No, three counties I was in.

Q. Were you conducting that survey for the Pennsylvania Justice Department or the United States Justice Department?

(78) A. United States Justice Department.

Q. You stated in your direct testimony that you felt there were good community programs in Pennsylvania?

A. Yes.

Q. Would you please expand upon that, briefly?

A. The programs that I evaluated in Pennsylvania, when I compare those to community programs across the country, I would put them above average in quality. They have been developed on the basis of some very solid principles of normalization, developmental growth, individualization. They know the importance of the location of the facilities, the integration of the persons, the types of activities the persons learn to do, so I would put them above average, certainly above average in quality, of the community programs that I have evaluated.

Q. You are referring here to what I think we would call community living arrangements?

A. Yes.

Q. Are you familiar with Pennsylvania Family Resource Services Programs?

A. What?

Q. Do you have an opinion as to the quality of that (79) program?

A. I'm not sure I know enough about it to speak to that. I believe some of the services that we evaluated during the workshops—No, I better not speak to that. They were just developing Family Resource Services as a unit within the Department of Mental Retardation under the welfare office when I first started doing workshops, so—

Q. And you started doing the workshops in 1972 or 1973, is that correct?

A. I believe so. They hired a staff member away from me when I was in Omaha to go head up the newly-budding division of Family Resource Services.

Q. So you wouldn't know what the status or funding of the Family Resource Services Program would be at this date?

A. Not unless, unknown to me, some of these services I evaluated last year were funded by them or partially supported by them. I don't know.

Q. For clarity of the record, I think I should define what I've been talking about. If you would like to do that instead of me, describe the services in the Family Resource Services Program as you know it in Pennsylvania.

(80) MR. FERLEGER: I think she said she doesn't know it well enough.

MR. HOFFMAN: I believe—

Q. Will you describe for us generally the purposes of the Family Resource Services Program in Pennsylvania?

MR. FERLEGER: If you know.

A. I don't know currently, today. I knew back when they were starting, what they were starting it for. I don't think I can speak on it today as the range of services under that particular component of mental retardation services.

Q. Are you familiar with the admissions process by which juveniles would be admitted to institutions in Pennsylvania as you have defined them?

MR. FERLEGER: Are you referring to the statutes involved that are, I think, Paragraphs 2, 3,

or 4 of the Court's opinion, or are you referring to the regulations or are you referring to something else?

MR. HOFFMAN: I'm asking Miss Glenn her understanding of the admissions process in Pennsylvania and then we will explore it from there.

THE WITNESS: The only thing I'm familiar with is the one I responded to. That was the one—Footnote 5 of the order.

(81) Q. Do you know how many applications for admission of juveniles to institutions are received annually in Pennsylvania?

A. No, I don't.

Q. Would you have any estimate of what percentage of those admissions—at this point, I think I'd be referring to public institutions—are accepted for admission?

A. No, I have no idea.

Q. Do you know whether Pennsylvania public institutions accept the referrals directly from parents?

A. No, I do not.

Q. Would it change your opinion in any way that you have expressed in your direct examination if I told you that referrals were not accepted at most public institutions directly from parents?

MR. FERLEGER: Are you speaking, Mr. Hoffman, of juveniles or adults?

MR. HOFFMAN: I'm speaking regarding juveniles in all cases, since that's what the focus of this lawsuit is.

MR. FERLEGER: You're also speaking of mentally retarded juveniles?

MR. HOFFMAN: That's correct.

(82) MR. FERLEGER: But the regulations say that there has to be a referral, that it can't be by the parents, so I don't understand the question. How could that change her opinion if the regulations say that the parents don't do it directly, but it has to be through a referral?

Maybe I misunderstood.

MR. HOFFMAN: Maybe you did.

Q. Do you know whether the institutions have—what processes the public institutions have for considering the appropriateness of an application of a juvenile mentally retarded person to that institution?

A. In Pennsylvania?

Q. Yes.

A. No.

Q. Do you know whether they require the referring agency, psychologist, or other referring entity, to have explored alternative community placements?

MR. FERLEGER: Objection. Procedures are listed in regulations, which don't require exploration of alternatives. If there is any such requirement, it hasn't been brought to the attention of the Court in this case.

Q. Would you please respond to the question?

(83) A. The only thing I'm aware of is this set of regulations we dealt with today.

MR. FERLEGER: If there are any other regulations, Mr. Hoffman, maybe you should unveil them now so we can see what the secret rules are.

MR. HOFFMAN: I don't think I stated there are any additional regulations.

Q. I think you stated that—if I'm incorrect, please correct me—that one of the problems in identification of persons who may be mentally retarded is over reliance or exclusive reliance upon IQ tests at the expense of considerations of adaptive behavior and problems in adaptive behavior and whether those problems arose during the developmental stage, is that correct?

A. That's one problem.

Q. Do you know what the definition, statutory definition, of mental retardation is in Pennsylvania?

A. No.

Q. Would it change your opinion with that problem if I told you that the definition in Pennsylvania includes those three factors?

A. No, because that's common in many states. But still there is reliance on IQ's. People don't go back (84) to the regulations for day-to-day decisions.

Q. Would your opinion about the inherent conflict of interest in the institutional staff making the admission decisions be changed in any way if I told you that an overwhelming percentage of applications for admission were rejected by the institutions?

A. No.

Q. Why not?

A. Because there are too many other factors that come into play. The rejection of a percentage or a large percentage or a substantial percentage does not mean

that, for political reasons or any other reasons, they would not accept any one individual, and that would be inappropriate for that one individual. There is no check and balance on the system right now if the institution is the decision maker.

Q. So because in what might be isolated instances, there may be what you would consider to be an inappropriate decision by an institution that a person should be placed in that institution, you would still feel there is an across-the-board bias of institutional personnel in making those decisions?

MR. FERLEGER: Objection. You are following (85) up a question that included an assumption that just because a large proportion of applications might be rejected, that those that are accepted somehow are made more valid. It's like if you have 100 applications and you only accept five, the fact that you rejected 95 doesn't mean that the five should have been accepted.

MR. HOFFMAN: Miss Glenn stated in her direct examination that the institutional staff could not be trusted to make a decision because of what I took her to be saying was an inherent bias on their part. I am asking her whether, if the facts do not demonstrate that across the board, whether she still holds that opinion.

MR. FERLEGER: She already told you the facts do not demonstrate that. You mean across the board in every admission?

MR. HOFFMAN: Yes.

MR. FERLEGER: Bias can still be there even if you say I don't want this person to come into

the institution. You can still incline toward accepting the person even if your ultimate decision is to reject the person.

MR. HOFFMAN: I'm trying to explore whether (86) Miss Glenn would offer her opinion if facts do not support that on an across-the-board basis.

MR. FERLEGER: All right, objection.

THE WITNESS: The fact that a period of time where a certain individual superintendent or staff member did not accept people into an institution doesn't set out any standardized procedure to be sure that doesn't happen for any one individual at any other time. It's still personality based and subject to any number of decision-making reasons that have no relationship to the needs of a person that is being considered for that institution, so it would not change my opinion.

Q. I'm somewhat flattered, I must say, that in discussing who is the appropriate person to make decisions about the appropriate placement for mentally retarded individuals, that you have found courts and lawyers to be that person.

Have you found courts to be particularly well informed about mental retardation?

MR. FERLEGER: Objection. That misstates her testimony. Miss Glenn suggested a process for decision making, rather than any particular individuals (87) for appropriateness of that test, and I object further on the basis that the courts deal with the most technical problems in every area of life. They deal with who worked out the first concepts

for making some industrial machinery and copyright cases. They deal with autistic law, they deal with the most complicated aspects of manufacturing in liability suits.

So whether or not a particular judge or judges generally know a lot about retardation has nothing to do with this case.

Q. In the hearing model that you described, you provided that a judge would make the final decision regarding whether a placement was appropriate and what that placement would be, is that correct?

A. A judge or judges or—I said a judicial process, and I have found, to answer your previous question, that on individual cases, and I appear in court a lot on individual cases, that the impartial review of the judge in that system—the Court does several very important things. It focuses the attention of everybody on the individual and his rights, and I have found that process to work very well to ensure that the results of those proceedings are fair and (88) accurate and the rights of the individual are foremost in the decision process.

I have not found that when professionals are involved because of built-in biases and ideologies of what should happen to people.

Q. Have you found the judges are well informed about mental retardation itself?

A. I've never discussed really with the judges that have heard cases their knowledge of the medical or social aspects of retardation. I couldn't answer that.

They deal with the facts of the case and the presentation of witnesses and the lawyers. I've never gotten into that with them.

Q. Have you found that judges are well informed about community alternatives for placement of mentally retarded persons?

A. I don't think they have to be, but I have as of late, yes.

Q. Have you found that defense attorneys or attorneys assigned to represent a person alleged to be mentally retarded are informed about mental retardation?

A. Oh, yeah, as of lately with all the advocate groups and the appointment of lawyers with specialties of (89) areas like mental retardation, they know a lot more than people involved in social services lately.

Q. Is it your opinion—excuse me, strike that.

Were you an expert witness for the plaintiff in the case of Halderman versus Pennhurst?

A. I think they were plaintiff intervenors, the United States Justice Department.

Q. Is it your opinion that an institution as you have described it is never, except in the rarest of circumstances, an appropriate placement for a mentally retarded individual?

A. Yes.

Q. Is it your feeling that the present—

A. Let me back up. The definition I gave you of an institution, if you get to a very small, specialized facility, under my definition may meet the definition of an institution; but it's very small, 10 people, five people, very specialized, for a short period of time for a very specific purpose, like a medical stabilization need of an individual that would take two months or so. Then that's appropriate.

Q. I understand that. Is it your opinion that the present processes for admission of juveniles are defective

in large part because they result in placement in institutions?

(90) MR. FERLEGER: Objection. Miss Glenn was asked her opinions about what ought to be the case. She was not, as I recall, asked her opinion about the general present processes, except perhaps for the regulations.

Q. Please answer the question.

A. Could you restate it?

(Question read back.)

THE WITNESS: Partially. The decision-making process for placement into any program is defective in social service agencies; but, yes, commitment proceedings, because they have only looked at instiitions, are defective because of that. That's all they have looked at in most cases.

Q. Do you consider yourself capable of deciding what would be an appropriate placement for a mentally retarded individual?

I'm assuming here that you have had the opportunity to examine the juvenile, to meet with his or her parents, that you have knowledge of the community services, either residential or otherwise, that would be available.

MR. FERLEGER: Mr. Hoffman, are you also assuming that she has resolved the factual conflicts (91) and all those other considerations—

MR. HOFFMAN: I'm assuming she is possessed with all information that she would deem necessary to know about a mentally retarded child prior to making a decision about whether some placement was necessary or not.

THE WITNESS: I am capable, professionally, to make a decision about the type of service needs a person has, yes. I do not personally possess the skills to resolve factual problems, resolve conflict.

I don't know if that answers your question. I can evaluate a mentally retarded child, and if it has been deemed—I don't think I possess, alone, the capability of saying a person should be taken out of their own family. I could say clinically, with the family and with the child, what services that child would need, whether in the home, whether somewhere else, what type of environment, what type of objectives should be checked, how that should be done from a clinical standpoint.

I can take a child in an institution and say what type, if he could not go back into his home for any reason, what type of community residential program, what type of community day training, what type of ancillary services that (92) would best meet the objectives of the child. I could not, as a professional, make a decision about taking a child out of a home, however, no.

Q. I'm not sure I understand the distinction you are trying to make.

You could not make a decision to take a child out of a home. Why not?

MR. FERLEGER: It's not her job.

Q. I think my question is whether, if parents of a mentally retarded child approached you as a professional and explained to you a family history and permitted you to examine that child and to become informed about the

family history, if you could make an appropriate decision as to what types of services were necessary for that child?

A. It would be a very rare instance that the first decision should not be what types of services were necessary to keep that child in their own home. On instances of should the child be taken out of the home, that's more of a welfare abuse, neglect type of decision that I am not professionally prepared nor capable of making.

Q. When we are talking about taking the child out (93) of the home, my question is not limited to taking the child out of the home and placing him or her in an institution that you think is undesirable.

It also includes placing a child in a setting that you think is conducive to his development. Does that alter your answer in any way?

A. I was thinking of that when I answered, so, no, it doesn't.

MR. FERLEGER: I want to object to any further questioning along this line because I think that Miss Glenn's hesitations and her obvious concentration in trying to answer this question are due to the fact that the questions are objectionable because they ask Miss Glenn, a mental retardation professional, to give us the ultimate answer to the legal and social questions that are before the Court.

I would also like the record to reflect my objection that the same questions have been repeated a number of times, and Mr. Hoffman has obviously not gotten the answer he wanted; but he got the answer. I think we should move on to something else.

(94) MR. HOFFMAN: The reason we are pursuing this line of questioning is that Miss Glenn testified a Court should make that decision, and I am trying to find out why Miss Glenn feels a professional such as herself is not as capable or more capable of making that decision.

MR. FERLEGER: My objection remains because this litigation is to determine whether a decision to deprive somebody of liberty is a decision that requires the traditional due process that our society requires for those decisions.

I have never heard it argued, for example, that a penologist who knows all about criminal behavior should be the one to decide whether a criminal is convicted or sentenced to prison for a crime.

In the same way, a mental retardation professional has no qualifications to decide whether someone should be deprived of liberty because they are retarded.

MR. HOFFMAN: I think the inappropriateness of your analogy is fairly apparent.

Q. You stated earlier—

MR. FERLEGER: It's in the eye of the beholder.

(95) MR. HOFFMAN: Thank you, Mr. Ferleger.

Q. You stated earlier that admissions of juveniles to institutions in Masschusetts have been closed.

Is that only to public institutions?

A. They have been closed—public institutions, yes, but it's not just juveniles. They have been closed to everybody.

Q. So do I presume that admissions of juveniles, mentally retarded persons, are continuing to be made to private facilities in Massachusetts?

A. Not through the Department of Mental Health.

Q. But they are continuing to be made outside the auspices of the Department of Mental Health?

A. Yes.

Q. In your opinion, are the hearings, judicial processes you have described necessary before a child could be placed in a community living arrangement?

MR. FERLEGER: Objection. She testified that institutions, because of the harm and the stigma and deprivation of liberty, require those kinds of procedures.

When somebody is living in a community, this lawsuit doesn't ask that any procedures be (96) adopted. So in addition to your having misstated her testimony, I object because the question and the answer, of course, are not relevant to the complaint in this case.

MR. HOFFMAN: We may disagree about the scope of the lawsuit, and I know that Miss Glenn stated that a hearing should precede an institutional placement. I'm not at all certain that she stated the converse of that, and I'd like to ask her that at this point, whether a hearing is required before a child would be placed in a community center.

MR. FERLEGER: Objection.

THE WITNESS: With my definition of community services?

Q. Yes, utilizing your definitions.

A. As stated in the earlier testimony, I would say no. But that is strictly with that definition. There are so-called community programs that deprive people of rights.

Q. But utilizing your definition, would you feel that parents, together with either social service personnel or mental retardation professionals, are sufficient to make that decision?

A. Yes.

(97) Q. I believe you mentioned somewhere in your direct testimony a respite care program?

A. Yes.

Q. Could you describe that for us briefly?

A. Respite care is a catchall term for a number of different types of services that can be provided for short-term assistance to the family in the way of babysitting services so the family can take a short vacation, to go out for the evening when they don't have a babysitter trained to take care of a multiply involved child, an out of home temporary short term, one day, two days, one week, so that the family can be relieved of some of the ongoing, 24-hours a day, 365 days a year burden and stress placed on the family sometimes because of the extraordinary needs of the child.

So respite care is for the purposes of family rather than training or treatment for the child.

Q. Does that program have as one of its goals to relieve tension on a family and thereby encourage families to keep mentally retarded individuals within the household?

A. Yes.

(98) Q. Does interim care ever involve a residential placement out of the home?

A. You are talking interim like I am—

Q. Excuse me. Respite care?

A. Yes, it does.

Q. Do you believe a judicial hearing as you have described it is necessary before that type of placement is made?

A. Not if it's short term and not to a facility that's going to deprive the person of rights and endanger her potentially.

Q. Are you saying that you do believe that a hearing, a judicial hearing, is necessary before respite care would be provided in an institution—

A. Institution, yes.

Q. —as you have defined it?

A. Yes.

MR. FERLEGER: I'd like to move to strike the testimony regarding respite care. There is nothing in the complaint regarding that matter, no facts that I know of before the Court except a couple of footnotes maybe in some brief of Mr. Hoffman's co-counsel on that issue.

I think it's not relevant. The standard (99) called for by the Court requires a hearing if the person is held longer than three days, so that if the person is institutionalized for longer than the three days, the hearing would be required. You are just calling it by a different name. I don't think there is any relevance.

MR. HOFFMAN: I think it's apparent from Mr. Ferleger's comments, and I agree with his char-

acterization of the Court's opinion, that the Court's opinion would require hearings prior to a respite care placement.

MR. FERLEGER: In an institution. We don't have anything in the record regarding any problems that occur or have occurred or even what the respite care program is.

MR. HOFFMAN: Except that the statutory basis for the respite care program would be the very statutory admission procedures that we are discussing in this lawsuit.

MR. FERLEGER: Not so far as I know or anything in the record indicates.

MR. HOFFMAN: Again, we have disagreements about the scope of the lawsuit.

MR. FERLEGER: I read the statute a number (100) of times since 1972 and so did a number of judges, and I haven't seen any indication in any of my readings or their readings that the statute talks about respite care. I don't see those words or any reference to that concept in the statutes or in the regulations that your department adopted.

Q. (By Mr. Hoffman) Do you believe that a hearing, as you have described it, is necessary before a child would be hospitalized for medical care?

A. No.

Q. Why not?

A. Hospitalized for medical care, I assume, means into an accredited hospital that is providing acute medical services on a short-term basis.

Q. I'm not certain we can make any of those assumptions. I'm not certain we can assume that a parent is placing a child into an accredited hospital, and I don't know that we can assume that the placement is short term.

MR. FERLEGER: I object. Your question becomes so vague that it's meaningless.

THE WITNESS: I don't think that I can answer.

Q. Do you believe that a hearing would be required (101) before a parent can place a child in a medical facility for a long-term course of medical therapy, possibly chemotherapy, or, as another example, a procedure such as amputation followed by inpatient rehabilitation?

A. No.

Q. Why not?

A. Because there are enough procedures and precautions taken by the medical profession and the periodic review required—that is put on hospitals about the appropriateness of placement on an ongoing basis that those procedures are taken into account. There is enough pressure because of the fiscal costs within hospitals from the insurance companies, if they are picking it up, or the date, if they are to pick it up, to make sure that that person doesn't stay there any longer than necessary for that medical treatment. There is enough built-in precautions.

Q. In other words, you feel that nonjudicial mechanisms are sufficient to insure the appropriateness of that placement?

MR. FERLEGER: I think her testimony can stand on its own two feet without your interpreta-

tions. (102) If Miss Glenn has anything to add, then she should add it; but if she doesn't she need not.

THE WITNESS: There are so many—when you say nonjudicial, there are so many other things that affect appropriateness of placement or inappropriateness of placement in a hospital that I wouldn't want you saying nonjudicial to me and automatically say just an administrative procedure. That's not what controls hospitals, just an administrative procedure.

Q. I think you stated in your previous testimony that institutional staffs were generally ignorant of community alternatives, is that a correct statement of your testimony?

A. Of the total range of community alternatives, certainly.

Q. Do you have any reason to believe that's true of institutions in Pennsylvania?

A. Only that my understanding of institutions in Pennsylvania is that they are very typical of institutions across the country.

MR. FERLEGER: As a matter of fact, Bob, your own client's defense of the Pennhurst case rested on that very assumption, that Pennhurst and (103) Pennsylvania institutions were typical of those across the United States.

MR. HOFFMAN: I'm merely asking whether Miss Glenn has any reason to know specifically that the staffs in Pennsylvania institutions are ignorant of community alternatives, which is the statement that I think is contrary to fact.

THE WITNESS: I'll answer this way: I do know the structure of where institutions fit into and

do not fit into the entire availability of services in the Commonwealth of Pennsylvania. The base service unit structure. There would be a tendency, just from administrative separateness of the institution's actual operation from the community services as run through the counties and state funded community living arrangement programs through the base service units, there would be a tendency for them to know less about community programs in Pennsylvania than there would in Massachusetts, where there is a strong attempt to tie in the area office responsibility, which would also be similar to the base service unit responsibility, with the institutions. So there would be more of a tendency not to know in Pennsylvania than some (104) other states because of the administrative way they are structured.

Q. How would you safeguard that—strike that.

(Discussion off the record.)

MR. HOFFMAN: I have no more questions.

MR. FERLEGER: I have just one thing.

Redirect Examination

BY MR. FERLEGER:

Q. Commissioner Glenn, I appreciate your patience for these last three hours plus that we've been here.

Mr. Hoffman asked you about whether a hearing would be needed before a child was placed in a medical facility for some long-term medical care. I believe he used amputation as an example. You gave some reasons. I know that but for an opportunity to clarify those reasons,

Mr. Hoffman might cite in a brief or some reference just that part of your testimony rather than earlier parts of your testimony which referred to the same issues, so I'd like to know whether you see, in terms of medical care versus mental institutionalization distinction, any relevance (105) of the stigma involved, the institutional risks and dangers involved, and the life-long effect involved in the mental institutionalization situation?

A. Very definitely. A regular hospitalization is a valued part of a community. Thus, the stigma would not be attached to a person having been placed there for whatever acute problem that person had. There is certainly less likelihood for the institutional abuses to take place because of the protections of the operation of hospitals and the type of staffing patterns, the type of funding mechanisms that they have.

What was your third one?

Q. The life-long effect and the deprivation of liberty and the exposure to institutional dangers and risks.

A. The reasons for hospitalization are almost invariably short term. Otherwise, like if it was to go to a nursing home for a long period of time, yes, I'd say there should be a hearing. A nursing home is an institution also, but the short-term nature and the very objective oriented to solve the medical problem and get the person out avoids the risk of the long-term problems created by separation of that person from the community (106) environment and the experiences that I was talking about earlier.

Q. In terms of the social functioning of the medical hospital, does that differ in terms of its openness or its closedness from the mental hospital, mental institution?

A. If I understand what you mean, there is no incentive in a hospital setting for retaining a person there longer than necessary or for the overprotectiveness to develop concerning the client's activities or liberties or capabilities or restrictions on visitations or—if that's what you meant.

Q. In order for your earlier answer to Mr. Hoffman on this issue to be correct and complete, if, for example, he wanted to refer to it in a brief, would we have to include your answers to my questions on this redirect examination?

A. To be complete, yes.

MR. FERLEGER: No further questions. Thank you.

(Whereupon deposition was concluded.)

(107) CERTIFICATE

I, Cindy Marie Hansen, a Notary Public duly commissioned and qualified in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 7th day of April, 1978, the person hereinbefore named, who was by me duly sworn to testify to the truth of his knowledge concerning the matters in controversy in this cause; that he was thereupon carefully examined upon his oath and his examination reduced to typewriting under my direction; and that the deposition is a true and accurate record of the testimony given by the witness.

I further certify that I am not interested in the event of the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 10th day of April, 1978.

Cindy Marie Hansen

My Commission expires Feb. 25, 1983.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

OPINION AND ORDER

Before Honorable John J. Gibbons, Circuit Judge and Honorable Daniel H. Huyett, 3rd and Honorable Raymond J. Broderick, District Judges

HUYETT, J., May 25, 1978:

I. *Introduction*

In 1975, this Court, convened as a three-judge federal court pursuant to 28 U.S.C. §2281[1] held that certain provisions of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) providing for voluntary commitment and admission to mental health facilities were unconstitutional.[2] *Bartley v. Kremens,* 402 F.Supp. 1039 (E.D. Pa. 1975), *vacated and remanded* 431 U.S. 119 (1977). We concluded that these provisions failed to provide juveniles committed to mental health facilities with specific procedural rights guaranteed by the Fourteenth Amendment to the Constitution which could not be waived by parents, guardians, or persons standing *in loco parentis.*

[1] 28 U.S.C. §2281 (1970) provided that an application for an injunction against the enforcement of a state statute on grounds of unconstitutionality must be heard by a three-judge district court. This provision was repealed on August 12, 1976.

[2] Sections 402 and 403 of the 1966 Act provide in part:

Section 402. Voluntary admission; application, examination and acceptance; duration of admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

The Supreme Court vacated and remanded this case for further consideration in view of the passage by the Pennsylvania Legislature of the Mental Health Procedures Act of 1976 (1976 Act). 50 P.S. §§7101-7503 (Supp. 1977-78). The passage of the 1976 Act mooted the claims of the named plaintiffs[3] and, in addition, created distinctions, at least with respect to the governing statutory enactments, between mentally retarded and mentally ill juve-

[3] Under the 1976 Act, juveniles age fourteen and older are given essentially the same rights as are given to adults. The named plaintiffs in the original suit were all age fourteen or older; thus, they no longer had a live claim following the passage of the 1976 Act. *See Kremens vs. Bartley,* 431 U.S. 119, 126-27 (1977).

niles. It was the Supreme Court's opinion that, in view of these new statutory distinctions, the class action originally approved no longer met the requirements of Fed.R.Civ.P. 23(a). The Supreme Court therefore remanded "for consideration of the class definition, exclusion of those whose claims are moot, and substitution of class representatives with live claims." 431 U.S. at 135.

II. *Statutory Scheme*

We first consider the contours of the statutory scheme governing voluntary admissions and commitments of juveniles. A description of the statutory scheme is important in order to structure properly the subclasses to be maintained pursuant to Rule 23. Furthermore, a full understanding of the statutes is necessary to our determination of whether they satisfy the requirements of procedural due process.

A. *The Mental Health Procedures Act of 1976 (1976 Act)*

The 1976 Act repeals the provisions of the 1966 Act except as they relate to mentally retarded persons. Article II of the 1976 Act articulates the procedures for voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" that mandates full or parttime residence in a mental health facility.[4] Section 201 provides that "a parent, guardian, or person standing in loco parentis to a child less than 14 years of age" may apply for voluntary examination and treatment, and by so doing shall be deemed to act on behalf of the child.[5] Once a juvenile is accepted for voluntary examination and treatment, the 1976 Act requires that "an individualized treatment plan [be] formulated by a treatment team" within seventy-two hours[6]. The treatment plan must state whether inpatient

[4] Section 103 of the 1976 Act provides as follows:

> This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

50 P.S. §7103 (Supp. 1977-78).

[5] Section 201 of the Act provides as follows:

> Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. *A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child.* Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

50 P.S. §7201 (Supp. 1977-78) (emphasis added).

[6] Section 205 of the Act provides as follows:

> Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

50 P.S. §7205 (Supp. 1977-78).

treatment is necessary and, if so, the reasons for that conclusion.

Section 206 of the 1976 Act sets forth the procedures for withdrawal from voluntary inpatient treatment.[7]

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[7] Section 206 of the Act provides as follows:

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may affect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

50 P.S. §7206 (Supp. 1977-78).

Where the person committed is under the age of fourteen, his parent, legal guardian or person standing *in loco parentis* may obtain his release. In addition, "any responsible party" who believes that it would be in the best interests of the juvenile to be withdrawn from inpatient treatment may petition the Juvenile Division of the court of common pleas of the county in which the juvenile resides and request withdrawal or modification of treatment. Then the court must appoint counsel for the child and schedule a hearing within ten days to determine "what inpatient treatment, if any, is in the minor's best interest." 50 P.S. §7206 (b).

B. *Mental Health and Mental Retardation Act of 1966 (1966 Act)*

The 1966 Act was the focus of the original *Bartley* decision in which this Court declared sections 402 and 403 of that Act to be unconstitutional.[8] Following the passage of the 1976 Act, only mentally retarded juveniles remain within the ambit of the 1966 Act. Sections 402 and 403 provide, in brief, that mentally retarded juveniles age eighteen or younger may be admitted or committed[9] to a mental health facility upon the application of a parent, guardian, or person standing *in loco parentis*, and may withdraw only with the consent of the admitting party or his successor.

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[8] For the text of sections 402 and 403 of the 1966 Act, *see* note 2 *supra*.

[9] As the Supreme Court noted, 431 U.S. at 124 n. 4, neither party has read the statute as containing a distinction between juveniles who are *admitted* voluntarily under section 402 and those who are *committed* voluntarily under section 403.

C. *1973 Regulations*

The 1973 Regulations,[10] promulgated by the Secretary of Public Welfare under the provisions of the 1966 Act,

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[10] The 1973 regulations provide in part:

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is

augment the procedural rights given to mentally retarded juveniles by the 1966 Act.[11] Portions of the regulations apply to all juveniles aged eighteen and younger, such as the requirement that juveniles admitted to a mental health institution be referred by a mental health professional, pediatrician, general physician, or psychologist; that this referral include a psychiatric, medical or psychological evaluation stating specifically the reasons why the juvenile re-

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necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification.

[11] The parties have stipulated that the 1973 Regulations presently apply only to juveniles committed as mentally retarded under the 1966 Act. Supplementary Exhibit No. 13, Stipulation No. 38.

quires institutional care;[12] and that the Director of the Institution conduct an independent examination of the juvenile prior to admission.

Additional rights are available to mentally retarded juveniles thirteen years of age or older. These juveniles receive written notification explaining their rights and furnishing them with the number of counsel whom they may call for representation. If a juvenile age thirteen or older objects to remaining at the institution, a commitment hearing must be held pursuant to the procedures provided for involuntary commitment.[13] We note here, as we did in the original *Bartley* opinion, that the regulations designate no time by which a post-commitment hearing must be held. 402 F.Supp. at n. 5.

In sum, there are two completely distinct statutory schemes which are under attack in this lawsuit; one relating to the mentally retarded (1966 Act as modified by the 1973 Regulations) and one relating to the mentally ill (1976 Act). Furthermore, with respect to mentally retarded juveniles, older juveniles are given some rights not accorded the younger juveniles.

III. *Named Plaintiffs*

There are twelve named plaintiffs in this lawsuit. Nine are mentally ill juveniles, age thirteen or younger, who were committed to mental health institutions pur-

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[12] *But see* note 55 *supra*.

[13] The procedures for emergency commitment and civil court commitment of mentally retarded juveniles are contained in sections 405 and 406 of the 1966 Act. 50 P.S. §§1405 and 4406. These sections are not challenged in this lawsuit.

suant to the 1976 Act.[14] The remaining named plaintiffs are mentally retarded juveniles, age fourteen or older, institutionalized under the 1966 Act and the 1973 Regulations.[15]

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[14] Four of the mentally ill juveniles have been discharged from Haverford State Hospital since the filing of the amended complaint. At the hearing held March 31, 1978, counsel for the Commonwealth moved for the dismissal of the claims of these plaintiffs on mootness grounds. However, we believe that these claims are not moot. *See Souder v. McGuire*, 423 F.Supp. 830 (M.D. Pa. 1976); *Meisel v. Kremens*, 405 F.Supp. 1253, n. 2 (E.D. Pa. 1975). These plaintiffs retain an interest in receiving declaratory relief, since the possibility remains that they could at any time be recommitted to a mental health facility under the challenged statutes.

[15] The named plaintiffs' medical records were offered into evidence at the hearing. Each plaintiff's records are divided into two portions: Part A consists of pre-admission background information, and Part B contains records from and including the actual admission note through the first staff conference. There was no objection to Part B, and those portions of each child's records were admitted into evidence. However, Part A was objected to by the plaintiffs on relevance grounds. Since there was no showing that these records were in the hands of the admitting officials and used by them at the time of the admissions, plaintiffs objected to the relevance of using these records to demonstrate that the defendant institutions engaged in a complete evaluative process prior to the decision to admit. We took the issue of the admissibility of these records under advisement.

Defendants subsequently submitted with their Supplemental Brief affidavits confirming the fact that virtually all of the information was received by the admitting facilities prior to admission. However, there still is little evidence showing in what way, if at all, these records were used during the admissions process. Plaintiffs have suggested that the material be admitted for the limited purpose of providing information on the social and family backgrounds of the named plaintiffs. After examining these rec-

Plaintiff Kevin S., age twelve, was admitted to Haverford State Hospital (Haverford) on July 18, 1977, pursuant to section 201 of the 1976 Act. Kevin's medical records reveal that his mother, who is separated from his father, has a history of serious mental illness, including incidents of hospitalization. Consequently, much of Kevin's youth has been spent in foster homes.

Prior to his commitment to Haverford, Kevin came to the attention of school authorities because of his inappropriate behavior, such as "making weird noises, refusing to do work, and talking back to teachers." A consulting school psychiatrist diagnosed Kevin as a "disturbed child" and recommended placement in Haverford. Kevin's psychological evaluation, performed after his admission to Haverford, describes him as a "very needy, very angry boy" who was "not currently seen as psychotic, although there is a tendency toward projection and a lack of control where anxious." His Admission Note, also prepared after his admission, gives as the "reason for admission:" "Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately." Kevin's psychological history concludes, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life."

Richard S., age thirteen, was committed to Haverford by the county child care agency on June 6, 1976 pursuant to section 201 of the 1976 Act. Richard has spent almost

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ords carefully and considering the memoranda submitted by counsel, we believe that Part A of each of the medical records is relevant to issues in this case and admit those portions into evidence.

all of his life in foster homes and residential homes for difficult children, with the exception of a two-year period between the ages of two and four. His Admission Note for Haverford states, as a reason for admission: "Inability to adjust to an open setting. History of self harm and running away."

Plaintiff James Paul M., age eight, was admitted to Haverford on October 17, 1977, under section 201 of the 1976 Act. His mother had died approximately one year before his admission to Haverford. The stated "reason for admission" to Haverford was "uncontrollable behavior" and "learning disability."

Plaintiff Raymond C., age thirteen, was admitted to Haverford on September 28, 1977, pursuant to section 201 of the 1976 Act. Raymond was admitted initially for purposes of "evaluation." The reason given for his admission was "History of uncooperative disruptive and aggressive behavior including run [sic] away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem."

William B., age nine, was committed to Haverford by his father pursuant to section 201 of the 1976 Act on September 21, 1977. For about two years prior to his commitment, William had been living with his natural father, stepmother, and two stepbrothers. The stated reason for his hospitalization was William's "uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window."

Twelve year old Edward B. was committed to Haverford on May 9, 1977 pursuant to section 201 of the 1976 Act. He has subsequently been discharged from Haverford.

Hospital records show that Edward was not informed that he was to be admitted to a mental health facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner." The stated reason for his admission was that Edward was "Hyperactive with poor behavioral control; threatens to hurt himself; feels depressed."

Plaintiff Francis B., age ten, was originally admitted to Haverford pursuant to section 403 of the 1966 Act on August 16, 1976. Subsequently, on September 7, 1976, Francis' father executed a form committing Francis to inpatient treatment pursuant to section 201 of the 1976 Act. While no "reason for admission" is given in the Admission Note, the examining physician stated that Francis had "difficulties adjusting to school" and that he has been described as "hyperactive with short attention span." Francis B. has subsequently been discharged from Haverford.

Plaintiff Maria L., age twelve, was admitted to Haverford on April 25, 1977, pursuant to section 201 of the 1976 Act. The Admission Note states that she was admitted because of "difficulties adjusting to school because of aggressive behavior . . . [and] difficulties adjusting within the family." Maria has subsequently been discharged from Haverford.

Plaintiff Thomas W. is eleven years old. He was originally committed to Haverford under section 302 of the 1976 Act (Involuntary Emergency Examination Treatment), which was subsequently changed to a section 201 commitment. The stated reason for admission was

Thomas' violent behavior. Thomas has since been discharged from Haverford.

The three remaining named plaintiffs are committed to institutions for mentally retarded pursuant to the 1966 Act. Plaintiff Nancy Louise D., age seventeen, was admitted to Polk State School and Hospital (Polk)[16] and is being confined pursuant to the terms of the 1966 Act. She was living in a foster home until institutionalized on May 22, 1968. Nancy Louise is categorized as being moderately retarded.

Plaintiff Gina S., age sixteen, was admitted to Polk on October 20, 1970 by her mother. She is currently being confined under section 402 of the 1966 Act. Gina's medical records state that she is functioning in the moderately retarded range of intelligence.

Plaintiff George S., age fourteen, was admitted to Pennhurst State School and Hospital (Pennhurst) on November 5, 1969, under the voluntary admission provisions of the 1966 Act in response to a request by Catholic Social Services. Prior to his admission to Pennhurst, he had been living in a foster home until his foster mother became unable to care for him. George is classified as being severely retarded.

IV. *The Class*

The Supreme Court cautioned that "careful attention must be paid to the differences between the mentally ill and mentally retarded, and between the young and the very

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[16] Nancy Louise D. was admitted to Polk on May 22, 1968. Her application form for admission shows that she was admitted under the authority of the Mental Health Act of 1951, rather than the 1966 Act then in effect.

young." 431 U.S. at 135-36. In response, we have painstakingly reviewed the testimony given at trial and considered as well the supplementary evidence submitted to us on remand.[17] On the basis of the record before us, we find as follows.

As the Supreme Court noted, there are major differences between the mentally ill and the mentally retarded. Mental illness is a term which covers a plethora of problems ranging from severe withdrawal and psychosis, to emotional problems which are situationally based.[18] Mentally retarded persons, on the other hand, are defined as those with substantial intellectual subnormalities, coupled with impairments in adaptive behavior originating in the developmental period.[19] Approximately three percent of the population, or two to three million persons, are classified as mentally retarded. Eighty to eighty-five percent of those are only mildly retarded; however, even those who suffer from a minor impairment are at times institutional-

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[17] The parties stipulated as follows:

> The evidence which was admitted in the initial proceeding, including all testimony, depositions, exhibits, interrogatories, objections and rulings shall be deemed included in the record of these proceedings. Further, for the convenience of the parties and the Court, the printed Appendix, which was used in the Supreme Court, No. 75-1064, with permission of this Court shall be used in these proceedings.

Stipulation of Counsel No. 40, Supplementary Exhibit No. 40.

We accept the Stipulations of Counsel and incorporate them into our findings.

[18] Testimony of J. Feiner, Appendix at 467a, *Kremens v. Bartley*, 431 U.S. 119 (1977) [hereinafter cited as Appendix].

[19] Deposition of L. Glenn at 11. By contrast, a person age twenty who suffered brain damage as a result of an automobile accident would not be considered mentally retarded. *Id.*

ized.[20] Despite these differences between mental illness and mental retardation, the testimony reveals that, with respect to many of the crucial factors which this court must consider in determining procedural due process requirements, there is little difference between the two groups.

First of all, a similar kind of stigma attaches to institutional commitment whether the juvenile is classified as mentally ill or mentally retarded. Experts on mental illness and retardation testified that this stigma is imposed both outwardly, in that juveniles who have been in institutions encounter substantial obstacles in the community,[21] and inwardly, in that the self-image of the juvenile is almost always severely damaged.[22] Mentally retarded children who are institutionalized are often stigmatized as dangerous and aberrant, thus making their subsequent integration into the community even more difficult. Further, these children are deprived of non-handicapped role models and, as a consequence, tend to adopt behavior patterns which are not socially and culturally appropriate. These behavior patterns may continue after a child is released into the community and, in fact, serve to accentuate the existing community stereotype of the mentally retarded.[23]

Second, both mental illness and mental retardation are conditions which are subject to error in diagnosis and iden-

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[20] *Id.* at 9.

[21] *Compare*, Testimony of J. Feiner, Appendix at 474a-75a, *with* Deposition of L. Glenn at 25.

[22] *Compare* Testimony of J. Feiner, Appendix at 474a-75a; Testimony of M. Ingall, Appendix at 595a-96a; and Testimony of E. Messinger, Appendix at 621a-22a *with* Deposition of L. Glenn at 25.

[23] Deposition of L. Glenn at 26-27.

tification. Experts on mental illness in juveniles repeatedly emphasized that the problems of the juvenile are often closely intertwined with mental and emotional problems of other family members. Irrespective of this fact, the juvenile is often the person isolated as having the mental problems.[24]

Errors in identifying mentally retarded juveniles result from different factors. First of all, certain physical characteristics, *e.g.*, Down's Syndrome, have historically been associated with retardation. However, these associations may not necessarily be accurate. Second, certain physical handicaps may cause a person to be mistakenly labelled mentally retarded. An undetected hearing impairment, for example, may prevent a child from performing well on an I.Q. test. A child who lacks normal motor or speech capabilities, who is unable to communicate or behave like other children, may be mistakenly identified as being retarded.[25]

Third, conflicts between the concerns and interests of the parents, and the best interests of the child frequently arise with respect to both mentally ill and mentally retarded children. Experts on mental illness testified that parents often commit their mentally ill children because of pressures in the home related to the child, or because of the parents' inability to cope with the child's problems and lack of awareness of alternatives to institutionalization.[26]

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[24] Testimony of J. Feiner, Appendix at 467a-72a; Testimony of M. Ingall, Appendix at 588a-90a; Testimony of E. Messinger, Appendix at 616a-17a.

[25] Deposition of L. Glenn at 13A-14.

[26] Testimony of J. Feiner, Appendix at 472a-73a; Testimony of H. Kandler, Appendix at 553a-54a.

Similarly, parents of mentally retarded children are frequently subject to community pressure to institutionalize their children.[27] Other personal pressures, such as the parents' own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child although that course is not in the child's best interests.[28] Finally, the parents simply may not be aware of less drastic alternatives to institutionalization.[29] Because of these potential conflicts between the parent and child, experts who testified on behalf of both mentally ill and mentally retarded children were of the opinion that an impartial third party[30] should make the final decision to institutionalize a child, not only for the child's benefit, but also to reduce the trauma and guilt felt by the parents.[31]

Finally, testimony concerning the nature of the deprivation of liberty inherent in institutionalization and the impact of this deprivation upon the individual is similar for both mentally ill and mentally retarded children.[32]

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[27] Deposition of L. Glenn at 35-36. For example, parents who have not been exposed to mentally retarded children may become upset when their normal child associates with a mentally retarded child, who the parents perceive as being "different."

[28] *Id.* at 37-42.

[29] *Id.* at 57-58.

[30] The experts did not necessarily agree, however, as to the *identity* of the third party. *Compare, e.g.*, Testimony of J. Feiner, Appendix at 478a-79a, *with* Testimony of L. Tashjian, Appendix at 644a-46a, 652a.

[31] Deposition of L. Glenn at 57-58.

[32] *Compare* Testimony of J. Feiner, Appendix at 474a-75a, and Testimony of E. Messinger, Appendix at 620a-22a *with* Deposition of L. Glenn at 22-24.

One expert testified to the "derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits" which are the effects of institutionalization.[33] Institutions prevent persons from being exposed to normal community experiences and prevent individual growth. With respect to mentally retarded persons, these conditions may be rendered even more acute by the person's inability to protect himself against the dehumanizing effects of institutionalization.[34] Finally, these effects appear to be the same regardless of whether the institution is state-operated or privately-operated; the crucial variable is size.[35]

The ages of the mentally retarded juveniles covered by the 1966 Act range from adolescent to very young. However, we conclude that the same factors hold true irrespective of the child's age. Indeed, the danger of misclassification and the stigma of institutionalization fall more heavily upon the younger child, for whom the decision to institutionalize may effectively foreclose any opportunity to adjust adequately to life in the community. Conversely, there is no evidence to suggest that older mentally retarded juveniles have either a greater or lesser need for procedural due process protection. On the contrary, as with younger juveniles, an older juvenile who is mentally retarded may be functioning under the same disabilities which are pertinent here; that is, he may be unable to read or write, or to understand concepts such as the right to counsel.[36]

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[34] Deposition of L. Glenn at 23-24.

[35] *Id.* at 28. However, the stigma of being labelled mentally ill or mentally retarded remains, regardless of the size of the institution or the actual conditions therein.

[36] *Id.* at 64-65.

Therefore we conclude that the need for due process protection and the factors which this Court must consider in determining what process is due, are the same for older and younger mentally retarded juveniles.

V. *Plaintiff Class Action*

Plaintiffs have requested that they be permitted to bring this action on behalf of two classes in accordance with Fed.R.Civ.P. 23(a) and 23(b)(2).[37] One proposed

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[37] We approved a defendant class pursuant to Fed.R.Civ.P. 23(a) and 23(b)(2) of "directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare" by Order dated March 28, 1978. *Institutionalized Juveniles v. Secretary of Public Welfare*, C.A. No. 72-2272 (E.D. Pa., March 28, 1978). The defendant class representatives are directors of three state-owned and operated facilities and the Secretary of Public Welfare.

The parties have stipulated as follows:

> All mental health and mental retardation facilities in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare. As part of the approval/licensing, such facilities have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act.

Stipulation of Counsel No. 37, Supplementary Exhibit No. 13.

This stipulation serves to buttress our conclusion that there is no conflict between defendant class members because "the challenged statutes and regulations are applicable to all of Pennsylvania's mental health institutions, whether state-owned and operated, or privately-owned." *Institutionalized Juveniles v. Secretary of Public Welfare, supra.*

This stipulation also serves to distinguish the case before us from *In Re John S.*, 135 Cal. Rptr. 893 (Ct. App. 1977), where the court held that there was no state action present in a parent's de-

class would consist of juveniles committed as mentally ill and who are under age fourteen; the other class would be juveniles committed as mentally retarded who are age eighteen or younger. Mindful of the Supreme Court's instructions that we " 'stop, look, and listen' before certifying a class in order to adjudicate constitutional claims," we proceed to determine if these proposed classes may be properly maintained.

A. *Mentally Ill Juveniles Under Age Fourteen*

One proposed class consists of all juveniles under the age of fourteen who are subject to inpatient treatment under Article II of the 1976 Act. We conclude that the class meets the requirements of Rule 23.

This class consists of approximately 360 members[38] which is sufficient to meet the numerosity requirements of Rule 23 (a).

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cision to admit their minor child to a private mental hospital. The *John S.* court specifically held that the state "does not control either admissions or treatment policies of the private hospital to which [the] minor was admitted." *Id.* at 901. Therefore, since the parents had not invoked the aid of a state statute in committing their child to a private mental hospital, the state was in no way a party to the parental decision. *Id.* We believe that the situation in Pennsylvania, as reflected by this Stipulation of Counsel, mandates a different conclusion. Since the state actively regulates the admissions procedures of all mental health facilities within the state as part of its licensing power, children, who are "voluntarily" admitted to privately-owned facilities are confined pursuant to state law.

[38] See Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

The question of law common to all class members is the facial validity of those provisions of Article II of the 1976 Act which relate to the voluntary commitment of mentally ill juveniles under the age of fourteen.

Rule 23 (a) requires that the claims of the representative parties be "typical" and that those parties adequately represent the interests of absent class members. While it has been noted that there is difficulty in distinguishing between "typicality" and "adequacy" requirements, those two criteria may be taken in concert as requiring that (1) the named plaintiffs be members of the class; (2) the named plaintiffs have no interests antagonistic to those of absent class members; and (3) the named plaintiffs' attorney be qualified, experienced and generally able to conduct the proposed litigation.[39] *See Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975); *Eisen v. Carlisle & Jacquelin*, 391 F.2d 555 (2d Cir. 1968); 3B J. Moore, Federal Practice ¶23.07[1] (2d ed. 1977).

Nine of the named plaintiffs are juveniles committed as mentally ill who are under the age of fourteen; thus, they clearly are members of the class. There is no conflict between these plaintiffs and absent class members. Each class member, irrespective of that child's age, is confined under the same statutory provisions alleged to be unconstitutional. Therefore we conclude that the class itself is cohesive and free from conflict, and that the representative

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[39] We have no doubts concerning the caliber of representation provided by plaintiffs' counsel, as evidenced by the high degree of competence displayed by counsel throughout the course of this litigation.

plaintiffs, through counsel, will adequately and vigorously represent the interests of absent class members.[40]

Finally, the class meets the requirements of Rule 23 (b) (2), since "the party opposing the class has acted or refused to act on grounds generally applicable to the class," thereby making declaratory or injunctive relief with respect to the entire class appropriate. *See Goldy v. Beal*, 429 F. Supp. 640 (M.D. Pa. 1976) (three-judge court). We find, therefore, that this action may be maintained as a class action on behalf of all juveniles committed as mentally ill who are under the age of fourteen.

B. *Mentally Retarded Juveniles Age Eighteen Or Younger*

Plaintiffs also seek to maintain this action on behalf of a class of mentally retarded juveniles age eighteen or younger. This entire class is covered by the 1966 Act; however, as noted above, juveniles age thirteen and over are given additional protection by the 1973 Regulations. The Supreme Court expressly posed the question of whether differences between older and younger juveniles might render certification of a class embracing both groups improper. 431 U.S. at 135. Because of our finding that there are no significant differences between older and younger mentally retarded juveniles for due process purposes, and for other reasons stated below, we conclude that the applicable Rule 23 criteria are met.

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[40] Plaintiffs' counsel was appointed guardian *ad litem* for the the class in order to alleviate any potential problem caused by the difficulty of the class representatives, persons confined to mental institutions, to fairly and adequately represent the interests of the class. *See Goldy v. Beal*, 429 F.Supp. 640, 649 (M.D. Pa. 1976) (three-judge court).

This class consists of approximately 3,153 members,[41] which is clearly sufficient to meet Rule 23 (a) 's numerosity requirement. Of greater concern is the requirement that there be questions of fact and law common to all class members, since mentally retarded juveniles who are thirteen and over are given greater procedural protection pursuant to the 1973 Regulations than younger juveniles. However, the attack mounted here is against the entire statutory scheme, including both the applicable provisions of the 1966 Act and the 1973 Regulations. We have previously made a finding that, for procedural due process purposes, there are no significant differences between older and younger mentally retarded juveniles. Therefore, if the statutory scheme is unconstitutional with respect to the older juveniles who receive greater protections, then it is *a fortiori* unconstitutional with respect to the younger juveniles who receive far less protection.

The "typicality" and "adequacy of representation" requirements are also met. The named plaintiffs here are all age thirteen or older and are thus given greater protections under the 1973 Regulations than class members under age thirteen. However, all three mentally retarded plaintiffs were admitted to their respective institutions before they reached age thirteen and, therefore, were presumably not accorded the additional procedural safeguards at the date of their admission. Furthermore, we do not believe that the rights accorded to older juveniles following their admission, such as the right to request a hearing on the validity of their confinement, serve to create a conflict between the

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[41] *See* Exhibits A and B to Stipulation of Counsel, Supplementary Exhibit No. 13 (Defendants' Answers to Plaintiffs' Interrogatories).

older and younger juveniles.[42] First of all, we reiterate our conclusion that due process requirements are the same for both groups. Second, we note that, in order for the named plaintiffs to prevail on their claim that the statutory scheme is unconstitutional, it will be necessary for them to prove the unconstitutionality of the statute and regulations as applied to the less protected younger retarded juveniles.[43] Therefore, we conclude that this action is properly brought on behalf of a class of mentally retarded juveniles age eighteen or younger.

VI. *Discussion*

In our original decision, we concluded that the plaintiffs had a liberty interest, protectible under the Fourteenth Amendment, in not being institutionalized without due

[42] There is nothing in the record to show whether notice of these additional rights was given to the juveniles at any time after their thirteenth birthday. Indeed, it is unclear from the text of the 1973 Regulations whether they provide that a juvenile who attains the age of thirteen while institutionalized must be given notice of his additional rights at that time. *See* note 10, *supra*.

[43] We do not believe that it is necessary for the class representatives to have interests identical in every respect to all class members in order to adequately represent the class. What is important is that their interests be the same with respect to the rights sought to be asserted. "Whether a party adequately represents a class depends on all the circumstances of the particular case." *Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239 (3d Cir. 1975) (former employees who voluntarily terminate their employment are able to represent adequately a class of presently employed persons, absent a showing of genuinely antagonistic interests.) Where, as here, there is no conflict between the interests of the representative plaintiffs and the absent class members, and the circumstances clearly demonstrate that the representative plaintiffs will vigorously assert the interest of all class members, we believe that the class action is properly maintained.

process of law. 402 F.Supp. at 1046. Encompassed within this liberty interest is not only protection against physical restraint and confinement, but also protection of the juvenile's "good name, reputation, honor, [and] integrity." *Wisconsin v. Constantineau*, 400 U.S. 433 (1971), *cited in Bartley v. Kremens, supra*, 1046 n. 8. The protection of the plaintiffs' reputation interest is implicated because of the stigma attached to institutional commitment, a stigma which "may render civil commitment a more lasting abridgement of personal freedom than imprisonment for a crime." *Id.* at 1046. We reaffirm these conclusions.

We further determined that this liberty interest could not be waived by plaintiffs' parents, guardians, or persons standing *in loco parentis*. *Id.* at 1047. There may be instances where the congruence between the parents' interests and those of the child assure that the parents will arrive at a decision based upon the best interests of the child.[44] The evidence in this case overwhelmingly demonstrates that, due to the substantial potential for conflict between the interests of the parent and the child, this is not such a situation. *See New York State Association for Retarded Children v. Carey*, 357 F.Supp. 752, 762 (E.D. N.Y. 1973); *cf. Horacek v. Exxon*, 357 F.Supp. 71, 74 (D. Neb. 1973).

It has been argued that the parents' determination that institutionalization is the appropriate treatment for a child believed to be mentally ill or retarded is no different from the decision to provide any other type of medical treatment. We disagree. Unlike other kinds of medical treatment, a

[44] We do not mean to imply, however, that in such a case parents necessarily would have the right to waive the constitutional rights of their children.

substantial stigma attaches to institutionalization. This stigma coupled with the substantial danger of error in the diagnosis of mental illness and mental retardation, and the greater potential for long-term loss of liberty[45] create a situation substantially different from the treatment of other medical conditions. Furthermore, we perceive little or no parent-child conflict in the decision to give or withhold other kinds of medical treatment since a parents' interests are more likely to be similar to the best interests of the child. Therefore, we reaffirm our holding that parents may not waive the constitutional right of their child not to be deprived of liberty without due process of law.

We then turned to a consideration of what process was due. In responding to plaintiffs' allegation that they were deprived of certain specific procedural rights, we concluded that the juvenile plaintiffs were entitled to

> (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice,[46] including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if

[45] The testimony demonstrated that, with respect to mentally retarded children, the decision to institutionalize is often a long-term or even life decision. Deposition of L. Glenn at 52-53.

[46] Because of those cases where notice to the child might be meaningless, we found that, "until some other procedure is established, this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney." 402 F.Supp. at n. 19.

> indigent the right to appoint free counsel;[47] (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[48]

402 F.Supp. at 1053. While we set forth these detailed procedures, we also stated, "Our action is not intended to preempt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out." *Id.* at n. 16, *citing Miranda v. Arizona,* 384 U.S. 436 (1966) and *Morrissey v. Brewer,* 408 U.S. 490 (1971).

[47] It may not always be necessary to appoint a lawyer so long as a substitute procedure adequately protects the child's interest. For example, it may be sufficient to appoint a guardian, trained in the mental health field, who would advocate the child's interests or alternatively, have the power to retain a lawyer to do so. The important point is that the child must have a capable advocate who has the sole responsibility of advancing the child's best interests. However, until alternative procedures are designed which will adequately protect the child's interests, we adhere to our conclusion that counsel is required.

[48] We further noted that "we neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." 405 F.Supp. at n. 26. Except with respect to the right to notice and counsel, we concluded that "any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them." *Id.* We further concluded that, in the case where a child is unable to understand his rights, the attorney may waive these rights, and "the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate." *Id.*

To rephrase Judge Friendly, there is no single correct solution to the problem of safeguarding the interests of the juvenile plaintiffs; "more of one procedural safeguard may justify less of another." Friendly, *Some Kind of Hearing*, 123 U.Pa.L.Rev. 1267, 1302 (1975).

We reaffirm these conclusions, and make the following additions and clarifications. First, we reiterate the need for a hearing in all cases unless there is a valid waiver. The Supreme Court has dictated that, in identifying the specific content of due process, three factors must be considered: the private interest involved, the risk of erroneous deprivation, and the Government's interest, including any fiscal and administrative burdens that the additional procedures would entail. *Smith v. O.F.F.E.R.*, 431 U.S. 816 (1977); *Mathews v. Eldridge*, 424 U.S. 319 (1976). The juvenile's interest here is weighty, and the risk of erroneous deprivation, as noted earlier, is great.[49] We believe that a hearing would insure that the interests of the child are clearly represented, that alternatives to institutionalization are fully explored, and that the decision to commit the child is impartially made.[50] *See J. L. v. Parham*, 412 F.Supp. 112

[49] The Supreme Court recently emphasized the importance of preventing erroneous deprivations of protected rights, stating:

> Procedural due process rules are meant to protect persons not from deprivation, but from the mistaken or unjustified deprivation of life, liberty, or property. Thus, in deciding what process constitutionally is due in various contexts, the Court repeatedly has emphasized that "procedural due process rules are shaped by the risk of error inherent in the truth-finding process. . . ."

Carey v. Piphus, 46 U.S.L.W. 4224, 4227 (March 21, 1978) (citations omitted).

[50] Several experts testified concerning the function that a hearing would serve. *See, e.g.*, Deposition of L. Glenn at 55-59; Testimony of E. Messinger, Appendix at 623a-25a.

(M.D. Ga. 1976) (three-judge court); *Lynch v. Baxley*, 386 F.Supp. 378 (M.D. Ala. 1974).

Several issues should be considered at the hearing. First, the unbiased tribunal should determine whether, in fact, the child is mentally ill or mentally retarded. If this determination is affirmative, the tribunal should proceed to determine if commitment is necessary, if it will be beneficial to the child, and if it is the least restrictive alternative. *J. L. v. Parham, supra; Halderman v. Pennhurst State School and Hospital*, C.A. No. 74-1343 (E.D. Pa., December 23, 1977). Where the state sanctions the restriction of a child's liberty rights, such restriction should intrude upon those rights to the smallest possible degree necessary for the achievement of the purposes of the restriction. *Shelton v. Tucker*, 364 U.S. 479 (1960). *See Halderman v. Pennhurst State School and Hospital, supra*, and cases cited therein. While the tribunal should make findings to support its determination, these findings need not necessarily be made formally. It is crucial, however, that the tribunal make a good faith, independent determination that the above criteria are met before a juvenile is confined.

We reject the argument that a hearing should not be required because it might prove traumatic for the child. First of all, the expert testimony, for the most part, demonstrated that the effects of a hearing on the child and, in many cases, the parent would be beneficial.[51] For example, one expert testified, with respect to mentally re-

[51] Several experts testified that a hearing would serve a therapeutic function in some instances, in that the child would thereby be assured that the decision to commit him was made fairly and impartially. Testimony of J. Feiner, Appendix at 483a-84a; Testimony of H. Kandler, Appendix at 544a.

tarded children, that a hearing would enhance feelings of dignity and self-worth in the child, reduce the guilt feelings of the parents, and reduce interfamilial conflicts, if any exist, over whether the decision to commit the child is correct.[52] Secondly, we note that the attorney representing the child has the option of waiving the child's presence at the hearing if there is a potential for trauma, and the court may accept such waiver where the child's interests are not compromised. Finally, and danger of trauma pales beside the potential severity of the deprivation of liberty suffered by a child needlessly institutionalized. *See Dixon v. Attorney General,* 325 F.Supp. 966 (M.D. Pa. 1971) (three-judge court).

Finally, with respect to the nature of the tribunal, we state only that the tribunal must be neutral and unbiased. It is clear that "an unbiased tribunal is a necessary element in every case where a hearing is required." Friendly, *Some Kind of Hearing,* 123 U.Pa.L.Rev. 1267, 1279 (1975). Whether the tribunal should be judicial or administrative is not a matter best resolved by this Court at this time.[53]

In view of the guidelines set forth above, we turn to the specific provisions attacked here; namely, the 1973 Regulations and the 1976 Act.

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[52] Deposition of L. Glenn at 56-57.

[53] In our initial opinion, we stated, "Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearing the present facilities of the Commonwealth court system shall be used for these hearings." 402 F.Supp. at 18.

We have reconsidered this portion of our original opinion and conclude that the more prudent course of action is to permit the Commonwealth to determine what kind of "unbiased tribunal" should conduct these hearings.

a. *1973 Regulations*

As outlined above, these regulations augment the procedures of the 1966 Act, giving certain procedural rights to all juveniles and other additional rights to juveniles age thirteen and over. Since the passage of the 1976 Act, these provisions apply only to those juveniles who are mentally retarded. We conclude that these 1973 Regulations are not in accord with the requirements of due process.

One of the major deficiencies[54] of the 1973 Regulations is the absence of a procedure designed to achieve informed, impartial admissions. Under the Regulations, a juvenile under the age of eighteen may be admitted to an institution upon the referral of either a pediatrician, general physician, or psychologist,[55] with the concurrence of the Director of the Institution.[56] The referring pediatrician or general physician may have no knowledge or training

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[54] This discussion is not meant to be an exclusive listing of the procedural deficiencies of the 1973 Regulations. To the extent that the Regulations do not fulfill the requirements stated elsewhere in the text, we hold that they are unconstitutional.

[55] Under the 1973 Regulations a mentally retarded juvenile may be referred to either a "recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. . . . a pediatrician, or general physician or psychologist."

The Regulations required that referral of mentally ill juveniles, no longer covered under the Regulations, be accompanied by a psychiatric evaluation, stating "with specificity the reasons that the person requires institutional care." However, the 1973 Regulations permit "a medical or psychological evaluation" to accompany the referral of a mentally retarded juvenile. Further, it is not clear whether these "medical or psychological evaluations" must state the reasons for institutionalization "with specificity."

[56] The Regulations require the Director of the Institution to conduct his own independent examination of the juvenile.

whatsoever concerning the problems of mental retardation,[57] while the Director of the Institution, who has interests different from those of the child, may be placed into a position of conflict in making the decision to commit.[58] There is no assurance whatsoever that the interests of the

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[57] Plaintiff's expert on mental retardation testified that, since mental retardation is not a medical problem, physicians typically are not familiar with developments in the delivery of services to mentally retarded persons. Deposition of L. Glenn at 49. Other mental health professionals often make institutional referrals because of the pressures on them to find rapid placement for mentally retarded children. *Id.* at 50-51.

[58] Many of the experts commented on the conflict of interest which faces the Director of a mental institution in this context. *See, e.g., id.* at 46; Testimony of E. Messinger, Appendix at 629a-30a Dr. Messinger summarized these conflicts as follows:

> [P]sychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical. For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is severely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization." What do I then say to my colleague whose opinion I disagreed with?
>
> Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient. If I am the director of an adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting the adolescent. I am not saying this is done deliberately, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Id.

child will be weighed in making this decision. Therefore, this procedure does not provide the protections furnished by hearing before an "unbiased tribunal".

As for the additional procedural rights given to children age thirteen and older, we conclude that there are severe deficiencies in these procedures as well. First of all, the mentally retarded child who receives written notice may not be able to read the notice or comprehend the explanation of his rights contained therein. Assuming that the child does understand the notice, however, the burden of commencing the enumerated procedures rests with the juvenile; he must contact counsel or object to the institutionalization. As one of the experts testified, "It's putting an awful lot of burden on young retarded persons to stand up against a big institution." Deposition of L. Glenn, at 67. Once the child protests, there is no set time limit in which a hearing must be held. We believe that, especially in the case of retarded children, who may lack the ability to understand the notice given to them due process rights are violated in the absence of an automatic post-commitment hearing, to be scheduled within a reasonable time, and the presence of counsel to speak solely for the child's interests.[59] Therefore, we hold that the 1973 Regulations fall short of the minimum due process requirements we outlined above.

b. *1976 Act*

Article II of the 1976 Act, as noted above, specifies certain procedures for the voluntary "inpatient treatment" of mentally ill juveniles who are age thirteen or younger. We believe that these procedures do not meet due process standards.

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[59] We in no way imply, however, that the other rights we have enumerated do not also apply.

We will note specifically several of the deficiencies of the 1976 Act. The major deficiency is the absence of a required post-commitment hearing to be held within a reasonable time after commitment and the absence of counsel to advocate the interests of the child.[60] We believe that these procedural requirements are especially critical where, as here, the rights of very young children may be implicated. These mentally ill children may lack the ability and capacity to speak on their own behalf, as an older juvenile might be able to do, and their interests may be overlooked.[61]

The procedures governing withdrawal from inpatient treatment in no way cure the defects of the statute. Section 206(b) provides that "any responsible party" may

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[60] The Act does provide that "an individualized treatment plan" be formulated by a "treatment team." The Act further states that "A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professions." 50 P.S. §7106. There is no assurance of the treatment teams' independence from the inpatient facility into which the child is being committed; and, in fact, the medical records of the named plaintiffs in this case appear to demonstrate that the members of the treatment team are employed by or associated in some way with the admitting institution. Therefore, we believe that this portion of the 1976 Act, is essentially no different from the similar requirement of the 1972 Regulations that the Director of the Institution examine all juveniles referred to him before admitting them.

[61] One of the experts testified, with respect to mentally ill juveniles

> I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their dilemma, nor can they be aware of alternative forms of therapy. . . . I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Testimony of E. Messinger, Appendix at 631a.

petition the Juvenile Division of the Court of Common Pleas for the modification of or withdrawal from treatment, and at that time, a hearing will be held. Thus, again, rather than providing for automatic procedures aimed at protecting against an unconstitutional deprivation of liberty, the statutory scheme places the burden upon a "responsible party" to initiate the procedures to which the juvenile is entitled. This type of statutory scheme is unacceptable.

Accordingly, we declare that the procedures for voluntary commitment of mentally ill and mentally retarded juveniles, as set forth in the 1966 Act, the 1973 Regulations, and the 1976 Act, are unconstitutional on their face and as applied to plaintiffs, and enjoin their enforcement.[62]

We continue to retain jurisdiction over this action, as we have the inherent power to do. This will enable the parties to apply for amendment or modification of the Order of they deem it necessary.[63]

John J. Gibbons
C.J.
Daniel H. Huyett, 3rd
D.J.

Honorable Raymond J. Broderick dissents and will file a dissenting Opinion.

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[62] The foregoing shall constitute findings of fact and conclusions of law as required by Fed.R.Civ.P. 52(a).

[63] We have issued a detailed Order in compliance with Fed.R. Civ.P. 65(d) and the Supreme Court's decision in *Schmidt v. Lessard*, 414 U.S. 473 (1974).

IN THE UNITED STATES DISTRICT COURT FOR EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

INSTITUTIONALIZED JUVENILES in Pennsylvania institutions for the mentally ill and the mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S.; by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated

v.

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representatives of all others similarly situated

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ORDER

NOW, May 25th, 1978, for the reasons set forth in the accompanying Opinion, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. In accordance with Fed. R. Civ. P. 58 and 65(d), we set forth below the terms of the injunctive relief granted.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). Two classes are represented by the named plaintiffs:

(a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen;

(b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger.

2. This action is properly maintained as a defendant class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named defendants includes directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare.

DECLARATORY JUDGMENT

3. Section 402(a)(2), section 402(c) and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

4. Section 201, section 206(d), and, to the extent that it applies to juveniles under the age of 14, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

5. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require that mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing.

Counsel

6. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel or other trained representative for mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen; or if the child is indigent, the appointment of free counsel or other trained representative.

Presence of Child

7. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to afford to mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under the age of fourteen who are subject to commitment hearings the rights to be present with counsel or other trained representative, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

8. These sections of the 1966 Act and the 1976 Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen, find by clear and convincing proof that the juvenile is in need of institutionalization.

Probable Cause Hearing

9. These sections of the 1966 Act and the 1976 Act are declared invalid in that they permit detention of mentally retarded juveniles eighteen years of age or younger and mentally ill juveniles under age fourteen for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 5 through 7 above.

Full Commitment Hearing

10. These sections of the 1966 Act and the 1976 Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to mentally retarded juveniles eighteen years of age or younger or mentally ill juveniles under age fourteen a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 5 through 8 above.

Regulations

11. The regulations promulgated by defendant Secretary of Public Welfare to supplement the 1966 Act, published at 3 Pa. Bull. 1840 (1973 Regulations), are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all mentally retarded juveniles eighteen years of age or younger the rights delineated in paragraphs 4 through 9 above.

Admissions and Commitments of Plaintiffs

12. It is declared that all mentally retarded juveniles eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under the enumerated sections of the 1966 Act are unconstitutionally held and detained.

13. It is declared that all mentally ill juveniles under age fourteen admitted to mental health facilities in Pennsylvania under the enumerated sections of the 1976 Act are unconstitutionally held and detained.

Application for Treatment of Juveniles

14. It is declared that a parent, guardian, or person standing *in loco parentis* may initiate the temporary detention of a mentally retarded juvenile eighteen years of age or younger or a mentally ill juvenile under age fourteen in a mental health or mental retardation facility if the procedures and requirements of our Opinion and Order are fully complied with.

Requirements for Commitment

15. It is declared that all mentally retarded juveniles eighteen years of age or younger and mentally ill

juveniles under age of fourteen, who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other trained representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney.

Counsel

B. Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided for free.

Presence of Juvenile and Other Hearing Rights

C. Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

16. Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 15 may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel of other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting the rights to notice and to counsel or other trained representative, may also be waived by the juvenile's attorney or representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

17. It is ordered that the operation of section 402(a)(2), section 402(c), and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (1966 Act) is enjoined in that these sections of the 1966 Act are unconstitutional on their face and as applied under the due process clause of the Four-

teenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile eighteen years of age or younger under the 1966 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other trained representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other trained representative shall be provided free.

(3) Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

4. A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 16(a) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other trained representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, except the rights to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

18. It is ordered that the operation of section 201, section 206(b), and, to the extent that it applies to juveniles under the age of fourteen, section 205 of the Mental Health Procedures Act of 1976 (1976 Act) is enjoined in that these sections are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment of the United States Constitution. It is further ordered that the defendants and their

officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any juvenile under the age of fourteen under the 1976 Act to any mental health or mental retardation facility unless the juvenile is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the juvenile's attorney or other representative must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the Legislature establishes some other procedure consonant with our Opinion and Order, this notice must be sent not only to the juvenile but also to the Clerk of the Court with jurisdiction to be forwarded to the juvenile's attorney or other representative.

(2) Counsel or other trained representative during all significant stages of the commitment process; if the juvenile is indigent, counsel or other representative shall be provided free.

(3) Presence of the juvenile at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the juvenile is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and to counsel or other trained representative, any or all of the rights delineated in paragraph 17(A) may be waived by the juvenile, and the neutral tribunal may accept such a waiver upon approval by the juvenile's counsel or other representative and upon a finding that the juvenile understands his rights and is competent to waive them. Because there may be situations where the juvenile either does not understand his rights or is not competent to waive them, any or all of these rights, excepting to notice and to counsel or other trained representative may also be waived by the juvenile's attorney or other representative, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

19. It is further ordered that the defendant Secretary of Public Welfare and its officers, agents, servants, employees, successors, and those persons in active concert, or participation with them are enjoined:

Regulations

A. To promulgate and issue regulations and to publish them, within sixty (60) days as immediately effective requiring that all mental health and mental retardation facilities in Pennsylvania (see 50 P.S. §4102 and §7103 for the definition of "facility") adhere to the Opinion and Order in this action.

Notice of Order

B. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the Opinion and Order in this action.

Procedures for Children Already Admitted or Committed

C. To initiate procedures, commencing immediately, to assure that all juveniles eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 of the 1966 Act and all juveniles under age fourteen committed pursuant to §201 of the 1976 Act are either discharged or released or recommitted according to the procedures required by our Opinion and Order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and eighty (180) days of the date of this Order, unless an extension is granted by this Court for good cause shown. Notation shall be made upon the medical records of such juveniles that their discharge, release, or recommitment was effected pursuant to the Opinion and Order in this action.

Reports on Implementation

D. To report to this Court within ninety (90) days and again within two hundred and ten (210) days on

the steps taken and progress made in the implementation of our Opinion and Order. The two hundred and ten-day report shall describe, for each mental health or mental retardation facility, the number of juveniles released, discharged or recommitted.

John J. Gibbons
C.J.

Daniel H. Huyett 3rd
D.J.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted in Printing]

Before: John J. Gibbons, *Circuit Judge*, Daniel H. Huyett, 3rd and Raymond J. Broderick, *District Judges*.

BRODERICK, J., *dissenting*, June 14, 1978:

In 1975, this three-judge court held that the Pennsylvania statutes providing for the voluntary admission and commitment of juveniles to mental health facilities pursuant to the Pennsylvania Mental Health and Mental Retardation Act of 1966 were unconstitutional. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975). I dissented from that decision. *Id.* at 1054. On appeal, the Supreme Court vacated and remanded for further consideration on the ground that subsequent to this Court's decision, the Pennsylvania legislature enacted the Mental Health Procedures Act of 1976 which gives substantially greater procedural protections to the mentally and emotionally distressed admitted to mental health facilities. *Kremens v. Bartley*, 431 U.S. 119 (1977).

In remanding, the Supreme Court stressed that "careful attention must be paid to the differences between mentally ill and mentally retarded." *Id.* at 135-6. Although courts and legislators have in many instances failed to distinguish between the mentally and emotionally ill and the mentally retarded, there is no question that mental illness and mental retardation are separate and distinct conditions which require different treatment and/or habilitation. In keeping with the Supreme Court's mandate, we will discuss first the mentally retarded.

Mental retardation is an impairment in learning capacity and adaptive behavior. The legislation in question and the professionals in the field consider retardation as being distinct and separate from mental and emotional illness. There is no question, however, that the retarded, just as all members of society, may also suffer mental and emotional illnesses. The habilitation of the mentally retarded is primarily an educational and training process. Mental retardation is not an illness to be treated with drugs and the therapies which have been developed for the mentally and emotionally ill. Today, all experts in the field of mental retardation agree that with proper habilitation, the level of functioning of every retarded person is capable of improvement.

Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4100 et seq.

The statutes and regulations with respect to the voluntary admission and voluntary commitment of the retarded are the same statutes and regulations which were considered by this Court in the *Bartley* case. Sections 402 and 403 of the Act, which are presently applicable to the retarded only, provide that retarded individuals, age eighteen or younger, may be admitted or committed to a mental health facility upon the application of a parent, guardian, or person standing in loco parentis, and such a retarded juvenile is not free to withdraw from the facility without the consent of the parent, guardian, or person standing in loco parentis or his or her successor. Upon receipt of such an application on behalf of a juvenile for voluntary admission or commitment, the director of the facility must cause an examination to be made, and if it is determined that the retarded juvenile is in

need of care or observation, he or she may be admitted to the facility.[1]

Section 402 provides that at least annually, the admission must be reviewed by a committee, appointed by the director from the professional staff of the facility, to determine whether continued care is necessary, and at least every sixty days the juvenile is to be informed of the voluntary nature of his or her status at the facility.

The 1973 regulations, promulgated pursuant to the Act, specify the procedural rights of the retarded aged eighteen or younger. 3 *Pa. Bulletin* 1840 (1973). These regulations provide that the retarded juvenile must be referred to the mental health facility by a mental health professional, pediatrician, general physician, or psychologist, and such referral must include a psychiatric, medical or psychological evaluation stating specifically the reasons why the retarded juvenile requires "institutional care." The regulations also provide that the "Director of the Institution or his delegate, shall have conducted an *independent* examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile." The regulations do not specify when this examination must

[1] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility, §402, while the other is concerned with voluntary commitments, §403. Apparently, the main distinction in the two statutes is that under the latter section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

be conducted. They do, however, provide that a retarded juvenile thirteen years of age and older must receive, within twenty-four hours after admission to a mental health facility, written notification explaining his or her rights and furnishing him or her with the telephone number of counsel whom the juvenile may call for representation. In the event such a retarded juvenile objects to remaining at the institution, the director of the institution must notify within two business days the parent, guardian, or person standing in loco parentis, the referral unit and the above designated counsel in order that an involuntary commitment proceeding may be instituted pursuant to §406 of the Act. Neither the regulations nor the statutes provide with the §406 hearing shall be held. Nor do they make provision for the situation in which the retarded individual is unable to understand, and hence utilize, these protections.

There are grave questions concerning the constitutionality of any statute which provides for the "commitment" of a retarded child. Throughout history the retarded have been mistreated and their dire need for education and training ignored. Wolfensberger, *The Origin and Nature of Our Institutional Models* 3 (1975). Retarded children, children mentally and emotionally ill, and children adjudged delinquent, in many instances have been confined to the same institution. Only in relatively recent years have our legislative bodies and our courts recognized the distinction between the retarded, the mentally and emotionally ill and the law breakers. Mental retardation is not a violation of the law. Being mentally retarded does not make juveniles or adults dangerous to themselves or to others. The mentally retarded are persons who because of circumstances beyond their control,

are unable to function at the same educational and behavioral levels as others in society. They do require specialized education, training and care. This Court in *Pennsylvania Association of Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972), recognized that they have a constitutional right under the Equal Protection Clause of the Fourteenth Amendment to receive at least as much education and training as being given by the Government to others not retarded. All of this raises the question as to whether the retarded—persons who have not violated any laws, who are not dangerous to themselves or society and whose only need is for education, training and care—should be subjected to a court proceeding the end result of which is "commitment".[2] I readily agree that this question has not been briefed in this litigation and has not been presented for determination; but it does lend focus to the issues herein presented.

The majority opinion concludes that §§402 and 403, as supplemented by the 1973 regulations, are unconstitutional in that they do not provide sufficient due process safeguards. I am in complete agreement that the retarded have a constitutional right to education and training in the least restrictive setting. As found in *Halderman v. Pennhurst State School and Hospital,* 446 F. Supp. 1295, 1318 (E.D. Pa. 1977), institutionalization in an institution such as Pennhurst State School and Hospital (one of the two institutions in which named retarded plaintiffs reside) is not the least restrictive setting for the

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[2] *See* Herr, *Rights into Action: Protecting Human Rights of the Mentally Handicapped,* 26 Catholic University L.Rev. 203, 308 (1977).

habilitation of the retarded and minimally adequate habilitation cannot be provided there. However, saddling retarded juveniles with the additional due process protections mandated by the majority's order will do little if anything to assure that retarded juveniles will receive minimally adequate education and training in the least restrictive setting, particularly in view of the limited availability of such facilities.

The procedures mandated by the majority requiring a probable cause and full commitment hearing with the appointment of counsel go beyond the due process requirements of our law and is not in the best interests of the retarded juvenile whose sole need is for education, training and care. The majority opinion sets forth several reasons for mandating a probable cause and a full commitment hearing together with the appointment of counsel. One reason given is that there may be instances in which the parents' interests will be in conflict with the child's right to minimally adequate education and training. There may be instances where this is so, but the overwhelming majority of parents are committed to obtaining an habilitation program which will improve the level of functioning of their retarded child. Furthermore, the Act and regulations under the Act make it impossible for the parents acting alone to have their retarded child admitted to a mental health facility. The regulations make it necessary that the retarded juvenile be referred to the mental health facility by a mental health professional, pediatrician, general physician, or psychologist, and that the referral must include a psychiatric, medical or psychological evaluation setting forth what is needed by the retarded child. The regulations also require the Director of the mental health facility to conduct an independent

examination of the retarded child and if he or she does not agree with the opinion of the professional recommending the referral, the retarded child must be discharged from the facility immediately. I do not share the concern of the majority that the irresponsibility of a few parents provides sufficient reason for declaring unconstitutional these statutes which establish a voluntary procedure whereby parents acting in concert with the professionals in the field of retardation, together with the Director of the mental health facility, may obtain habilitation for a retarded child.

Another reason offered by the majority in support of its due process mandate is that a stigma attaches to a child who is classified "mentally retarded". There is no question that there are some who consider retardation to be a stigma. We are also aware that today a majority of our enlightened citizens recognize that mental retardation and mental and emotional illness should not be considered a stigma; handicap yes, stigma no. In any event, requiring the appointment of an attorney to represent the retarded juvenile and mandating a court proceeding will not alleviate the so-called stigma problem.

The majority also reasons that its due process order is necessary to protect juveniles who are not retarded from being admitted to a facility for the retarded. Such a juvenile would, of course, be the victim of an error by the professionals in the field. The mandated procedures will do little to eliminate such errors. I do not deny the wisdom of an appeal to the legal system when parties have a dispute. However, mandating a legal proceeding for the determination as to the kind of education, training and care which will be most beneficial to the retarded

juvenile is a decision more appropriately left to the professionals outside the judicial process.

We are here concerned with the procedures for the voluntary commitment and admission of the retarded juvenile to a facility providing minimally adequate habilitation in the least restrictive setting. The due process procedures mandated by the majority has, in effect, abolished the voluntary admission and commitment procedures for retarded juveniles, turning each admission into a court commitment procedure almost identical to the involuntary commitment procedure provided in §406 of the Act. The involuntary commitment procedure for juveniles, which has existed for many years, has certainly not eliminated nor alleviated those problems—irresponsible parents, stigma, errors in diagnosis, inadequate habilitation in restrictive facilities—upon which the majority bases its reasoning for declaring unconstitutional the voluntary admission and commitment procedures for retarded juveniles.

Mental Health Procedures Act of 1976, 50 P.S. §§7101-7503 (Supp. 1978-79).

The Mental Health and Procedures Act of 1976 has drastically changed the statutory scheme dealing with the mentally and emotionally distressed from that which was presented to this Court during the *Bartley* case. As a result of the new Act, we are presented solely with the due process claims of mentally and emotionally ill juveniles under the age of fourteen. Those mentally and emotionally distressed juveniles fourteen years of age and older, for purposes of the Act, are treated substantially the same as adults.

The Act provides that a parent, guardian or person standing in loco parentis to a child less than fourteen

years of age may subject the child to examination and treatment under the Act. §201. Upon acceptance for voluntary examination and treatment, the Act provides that the individual "shall be given a physical examination. Within 72 hours after acceptance . . . an individualized treatment plan[3] shall be formulated by a treatment team[4]. . . . The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions." §205.

A person under the age of fourteen may withdraw from the facility upon application of his or her parent, guardian or person standing in loco parentis. Additionally, "any responsible party" who believes that it would be in the best interests of the child to be withdrawn from

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[3] "'*Treatment plan*' means an individualized plan of treatment formulated for a particular person in a program appropriate to his or her specific needs, and to the extent possible, made with the cooperation, understanding and consent of the person in treatment, and imposing the least restrictive alternative consistent with affording the person adequate treatment for his or her condition, on forms developed by facility and approved by Department." Regulations implementing 1976 Act, §7100.1.2, 6 *Pennsylvania Bulletin*, 2115, 2116 (1976).

[4] "'*Treatment team*' means an interdisciplinary team of at least three persons appointed by the facility director, composed of mental health professionals and others. At least one member of the team shall be a physician. The treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this Act. The treatment team shall consult with appropriate persons regarding the inclusion in the treatment plan of specific modalities not within the training and experience of the members of the treatment team." §7100.1.2, 6 *Pennsylvania Bulletin*, 2115, 2116 (1976).

inpatient treatment or afforded treatment constituting a less restrictive alternative may petition the Juvenile Division of the court of common pleas for the county in which the child resides and request withdrawal or modification of treatment. The Act provides that once a petition is filed, the court must appoint counsel for the child and schedule a hearing within ten days to "determine what inpatient treatment, if any, is in the minor's best interest." §206(b).

The regulations promulgated pursuant to the 1976 Act give further procedural protections to the mentally or emotionally disturbed child under the age of fourteen. They provide that each individual shall be re-examined and his or her treatment plan reviewed not less than once every 30 days, and that on the basis of the re-examination and review the treatment team must either authorize continuation of the existing treatment plan, if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the juvenile. The regulations specifically provide that the child "shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his or her needs." §7100.1.6.3.C.

The regulations also provide for a "clearly defined" appeal system whereby any patient who wishes to voice objections concerning his or her treatment shall be heard, and shall have his or her treatment plan reviewed by a mental health professional independent of the treatment team who shall make a report of his or her review to the director of the facility. §7100.1.6.4.

Finally, the regulations establish a "Patient Bill of Rights" which is to be given to the child upon admission

to the facility, and is to be posted in each resident's living unit and treatment area. When the individual is unable to read, the regulations provide that the Bill of Rights is to be read and explained to the patient. Attached to the Bill of Rights are the names, addresses and telephone numbers of legal and other available advocacy services. The Bill of Rights provides:

YOU HAVE A RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:

a. To peaceful assembly and to join with other patients. To participate in or organize a body of patient government when patient government has been determined to be feasible by the facility.

b. To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.

c. To make complaints and to have your complaints heard and decided promptly.

d. To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others treatment or welfare.

e. To receive and send unopened letters and to have outgoing letters stamped and mailed. In-

coming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.

f. To have access to telephones designated for patient use.

2. You have the right to practice the religion of your choice or to abstain from religious practices.

3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you make and keep the proceeds from its sale.

4. You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying or obtaining a divorce and writing a will.

5. You have the right to participate in the development and review of your treatment plan.

6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.

7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.

8. You have the right not to be subjected to any harsh or unusual treatment.

9. If you have been involuntarily committed in accordance with civil court proceedings, and you

are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.

10. You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal Wage and Hour Regulations.

The 1976 Act and its accompanying regulations, including the Bill of Rights quoted above, provide sufficient due process protections to a mentally or emotionally ill juvenile under the age of fourteen. They provide that within 72 hours after admission, the mentally or emotionally ill child will be examined and a treatment plan formulated, the primary purpose of which is to determine what treatment, if any, is appropriate for the child. It provides for re-examinations of the juvenile and a review of his or her treatment plan at least every 30 days. An internal appeal mechanism is created whereby the juvenile may challenge the modalities of his or her treatment. A "Bill of Rights" has been drafted and circulated to insure that those admitted to mental health facilities are aware of their constitutional rights, and of mechanisms available to secure any rights which might be infringed. Finally, the Act provides that "any responsible party" who believes that it would be in the best interests of the child to be withdrawn from inpatient treatment or afforded treatment constituting a less restrictive alternative, may petition the court of common pleas and request withdrawal or modification of treatment. Once such a petition is filed, the court must appoint counsel and schedule a hearing within 10 days to "determine what inpatient treatment, if any, is in the minor's best interest."

Due process does not require a full judicial hearing in every conceivable case of governmental impairment of private interest. *Board of Curators of the University of Missouri v. Horowitz,* U.S. , 98 S.Ct. 948, 952 (1978); *Stanley v. Illinois,* 405 U.S. 645, 650 (1972). "[T]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation." *Board of Curators of the University of Missouri v. Horowitz,* 98 S.Ct. at 953.

As justification for the procedures which its order mandates, the majority stresses the potential for conflict between parent and child; the risks of misdiagnosis and stigma. As to the potential of conflict between a parent and child, the comments heretofore made in the discussion concerning retarded juveniles are equally applicable to mentally and emotionally ill juveniles. In addition, the due process procedure mandated by the majority, setting up, as it does, an adversary court proceeding, may discharge parents from seeking treatment for a child suffering a mental or emotional illness. These due process procedures might retard the progress which has been made encouraging parents to seek early treatment for a mentally ill or emotionally disturbed child. The comments made with respect to the risks of misdiagnosis and stigma, heretofore discussed in connection with mentally retarded juveniles, are likewise applicable. The possibility of a misdiagnosis and the fact that some people still consider mental and emotional illness a stigma should not subject all juveniles to the elaborate due process procedures ordered by the majority in today's enlightened society which has at last begun to recognize that mental and emotional illness is not a stigma to either the parents or child and should be considered and treated on the same basis as society accepts

and treats physical illness, i.e., with compassion and understanding. Moreover, as stated in connection with the mentally retarded, it is difficult to perceive how the procedures mandated by the majority will mitigate or eradicate the alleged conflicts between parent and child, misdiagnosis and the alleged stigma attached to the mental and emotional problems of juveniles.

As stated in the *Bartley* dissent, the majority has prescribed "an overdose" of due process which in effect abolishes the voluntary admission and commitment procedures for mentally and emotionally ill juveniles under fourteen years of age and for all retarded juveniles.

(s) Raymond J. Broderick
Raymond J. Broderick, *J.*